"What about accountability to the patient?"

r mesmerised me • my anger w ed against me • i wanted this man to stop hurting other women • the board has yet to do a s

lating • no efforts ha been find the truth • rapists are still practising today • what value is the le

oul murder • there is a power imbalance • i do not trust professionals to this day • th

ncing you • what about accountability to the patient • who else has bee

to do • i hope some good can come of this • i have a lot

"Who will help me heal?"

a thing • i cannot tell you how profoundly betrayed i was • i was humiliated • his pc

ation if it is not being implemented • they should not be self-r

oces abused my family too • it is simply call

t • they get away with

The Independent Final Report of the Special Task Force on Sexual Abuse of Patients

Marilou McPhedran, Chair
Dr. Harvey Armstrong • Dr. Briar Long • Pat Marshall • Dr. Roz Roach
Ronda Bessner, Expert Advisor

107444

“What about accountability to the patient?”

FINAL REPORT OF THE SPECIAL TASK FORCE ON SEXUAL ABUSE OF PATIENTS

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Task Force Members:
Harvey Armstrong • Briar Long • Pat Marshall • Roz Roach

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FROM THE PERSPECTIVE OF A COLLEGE

Of all the recommendations of the 1991 Task Force that became law, mandatory revocation by a college of the health professional's certificate, upon a finding of sexual abuse, has been hotly debated. This recent Discipline Committee decision examines the constitutionality of the mandatory revocation provision in the Code of the *Regulated Health Professions Act*.

"Section 51(5) of the Code does not regulate sexual relations per se: it regulates the way in which a doctor may practise medicine...the right to practise a profession is characterized as an economic interest rather than a legal right, and so is not the type of liberty which section 7 [of the Canadian Charter of Rights and Freedoms in Canada's constitution] is intended to protect...it is the view of the Committee that the proper characterization of subsection 51(5) is not to deprive physicians of their liberty, but rather to regulate the practice and behaviour of doctors within the practice of medicine. The practice of medicine in Ontario is a privilege, which brings with it certain obligations both to their patients, (to refrain from sexual relations), the public and to fellow members of the profession".

Excerpt from The College of Physicians and Surgeons of Ontario v. Dr. Anil Mendi Mussani and The Ontario Medical Association (1999)[under appeal]

FROM THE PERSPECTIVE OF A PATIENT

Excerpt from the May 24, 2000 Public Hearing of the Special Task Force. Question from the Chair of the Special Task Force to a patient, Janet, reporting her experience for the public record: ***"Tell me if you thought about what difference it would be for you in what you've gone through if you were a party to the proceeding..."***

Janet:

"You know what, nobody knew how well this man was lying as much as I did. There were so many occasions after he's on the stand testifying that I'd go up to the prosecution and I'd say, look it. They would say, 'I don't want to hear about the evidence. I don't want to hear about the evidence.' I heard that so many times. Well, you know what, they should have taken every single opportunity that I afforded them to show that this man was lying, you know. I should have been given a copy of the Regulated Health Professions Act. I wish I had read that before going in, because then I would have known what they were denying me, you know. I mean, the whole process it feels like, you know, here is this doctor, you know, he gets away with manipulating you and silencing you and then you go to the college and they get away with silencing you and then ignoring you. I was only of value until the testimony is over."

FROM THE PERSPECTIVE OF A JUDGE

Few patients reach the point of being able to marshal their resources to sue their abuser for damages, separate from the college process and from the criminal law process.

Few judicial decisions examine the dynamics of sexual abuse by a health professional thoroughly. For these reasons, we commend to the reader this excerpt from a judgment rendered by Justice J. Aitken of the Ontario Court of Justice (General Division) in 1998.

> *"She went to him for help at a time when she was particularly vulnerable and insecure. He had the professional knowledge to help her, but instead used that knowledge to manipulate the situation to his own advantage, playing on [her] lack of confidence, her search for a positive father-figure and her sexual inhibitions. In these circumstances, as has been attested by Dr. Jackson and Dr. Freebury, [the patient] could not exercise free will. Her participation in sexual activities with Dr. B. [a psychologist] was not based on any understanding on her part as to what was really happening. He kept her in a constant state of confusion as to whether his advances were part of her treatment, evidence of his love for her, or something else. This was coupled with her overwhelming dependency on him, which he let develop unchecked, so that she was rendered incapable of coming to her own assessments or conclusions. There could be no genuine consent in these circumstances. Therefore everything from the initial touching to the hugging, kissing, fondling, masturbating and finally intercourse were all forms of battery.*
>
> *I agree with McLachlin J. that '... where such a power imbalance exists it matters not what the patient may have done, how seductively she may have dressed, how compliant she may have appeared, or how self interested her conduct may have been - the doctor will be at fault if sexual exploitation occurs.'* (Norberg v. Wynrib (1992), 92 D.L.R. (4th) 449 (S.C.C.) p.497)
>
> *Exploitation did occur in this case, and the sole responsibility for that rests with Dr. B. There can be no doubt that [the therapist] owed fiduciary obligations to [the patient] when he took her on as a client within his clinical psychology practice. It is also equally clear that he breached those obligations by totally ignoring what were appropriate therapist-client boundaries and particularly by initiating and maintaining a sexual relationship with her. The obligation was on him and him alone to ensure the appropriate boundaries were maintained. By breaching them, he put his own needs ahead of those of [his patient]. He did not do this on just one occasion. He did it repeatedly from August 1990 to August 1995, and arguably beyond."*

Held: The court awarded the plaintiff damages of $326,275.98, including aggravated damages of $100,000, punitive damages of $25,000, and special damages of approximately $200,000. The court awarded the plaintiff's husband $30,000 in damages as compensation for the losses he had suffered and would suffer in the future as a result of the defendant's treatment of his wife. The plaintiff's injuries were the foreseeable result of the defendant's negligence. In assessing damages, the court started from the premise that absent the defendant's involvement, the plaintiff would have been living a normal, healthy life by December, 1993. She would have been working full time. She may have needed supportive counselling from time to time, but nothing in the nature of the intensive psychotherapy she had required since December, 1993 and continued to require. Aggravated damages were appropriate in this case. The defendant had breached virtually all standards of professional conduct; his negligence was so reckless and audacious as to shock the court.

FROM THE PERSPECTIVE OF AN ADVOCATE

"Particularly in the past four to five years, the proverbial pendulum has swung back in favour of a tangible bias against patients: so much so that many lawyers, including myself, cannot recommend that patients ever go to the college."

Susan Vella, Public Hearing of the Special Task Force, May 24, 2000

The views expressed herein do not necessarily represent the views of the Ontario Ministry of Health and Long Term Care or the Health Professions Regulatory Advisory Council.

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SPECIAL TASK FORCE ON THE SEXUAL ABUSE OF PATIENTS

Task Force Chair:
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Task Force Mandate:
To conduct an independent inquiry into the experiences of patients and members of the public on the subject of sexual abuse by regulated health professionals in order to provide *Advice and Recommendations* to the Health Professions Regulatory Advisory Council and the Minister of Health, as part of the five year review of *The Regulated Health Professions Act.*

Friday, November 10, 2000

The Honourable Elizabeth Witmer
Minister of Health and Long Term Care
Government of Ontario

Dr. Rob Alder, Chair
Health Professions Regulatory Advisory Council

Dear Madam Minister and Dr. Alder;

Pursuant to your letters of January 7 and February 23, 2000, we are pleased to deliver to you our Advice and Recommendations.

The Task Force office opened on February 16 of this year, and in addition to our meetings with HPRAC members and Ministry staff, members of our Task Force have met in person on 18 occasions, conducted a roundtable in cooperation with the Federation of Health Regulatory Colleges on May 12, received in-person reports from patients and advocates at the public and private hearings on May 24 and May 31, and held a roundtable with patients, advocates and educators on the topic of education and training on June 9. Through telephone hotline reports and interviews, letters and some email transmissions, we have received reports that we considered within our mandate from 57 patients or their representatives. Eighty per cent of the patients' reports were from women.

In preparing our independent report, we have been guided by the ten questions posed by you and an eleventh question on training and education, which we added. After considering reports from patients, documentation and commentary, we have the honour to present our Final Report including 34 Recommendations.

We appreciate this opportunity to be of service in the public interest.

Sincerely,

Marilou McPhedran
Marilou McPhedran

H. Armstrong
Harvey Armstrong

Briar Long
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Pat Marshall
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Foreword

BY N. JANE PEPINO, C.M., Q.C.

The moving personal accounts and compelling analyses that are presented in this Independent Final Report of the Special Task Force on Sexual Abuse of Patients provides important knowledge and practical recommendations to ameliorate the ongoing sexual abuse of some patients by some Health Professionals. To truly understand the impact of this particular type of violence to our society, however, it must be placed within an unfortunately broader context of violence against women and children, and some men, within Ontario and Canada. Just as Health Professionals are just one group of the spectrum of abusers, so, too, is sexual abuse just one category of abuse and violence. Though men and boys can be and are abused, the data available to us confirms that women and girls are subject to the highest incidence of abuse, including sexual abuse as patients.

In 1985, when METRAC (the Metropolitan Action Committee on Violence Against Women and Children) was founded by myself, Marilou McPhedran, Pat Marshall and others, it was the first such organization to tackle the ignorance about violence against women and children in our society, and to point out that continuing ignorance remained an enormous barrier to the safety of women and children, and their ability to live without the crippling behaviours that are the legacy of abuse. The pervading fear of violence, particularly random violence from strangers, shapes and constrains the lives of women and children. However, even more traumatic is abuse, and particularly sexual abuse, from a trusted individual: the betrayal of trust by an authority figure and personal confidante, such as a Health Professional, can be as destructive to self-esteem, trust and confidence as incest or family violence. I therefore commend the work of the Special Task Force in identifying continuing systemic barriers to safety, to redress those obstacles, and to advocate for appropriate standards for Health Professionals, and those who educate, regulate and discipline them in the public interest.

Until the work of the original Task Force on Sexual Abuse of Patients in 1991, sexual abuse by Health Professionals was ignored, denied, or misunderstood. What has become clear since 1991, however, is the particularly corrosive impact of this type of abuse, given the fundamental breach of a trust relationship, by those with greatest responsibility to build and maintain trust. What this current Final Report has also highlighted is the finding that the response of the system to victims of abuse has the potential of doing as much, or even more, damage than the original abuse itself.

In my experience, however, even more important than the Task Force's findings, are its recommendations for addressing ongoing problems: I find them workable, respectful, and eminently achievable.

First, from my present role as Chair of the Ontario Women's Health Council, I am pleased to note the significant parallels between this Special Task Force Report and some of the work of the Council with respect to education of

Health Professionals and of patients. It is fundamental that women's health be defined as more than simply biological, and include recognition of social and economic determinants as well. Obviously, freedom from violence and sexual abuse is fundamental to a healthy life. Surely it is not wrong to expect that the Health Care System, intended to be committed to promoting and maintaining health, be entirely free from violence and abuse. Therefore, implementation of the Task Force proposals would include the development of very necessary comprehensive, effective abuse prevention programs. In addition, the recommendation of this Report for the mandatory posting of a Patients' Bill of Rights in every health care office and facility could further Council's goal of ensuring access to supportive and gender appropriate information and health care.

As a practising lawyer, I am, like doctors and other Health Professionals, a member of a self-regulating profession. Any debate about changes to self regulation, to address standards for behaviour of a member of self-regulated professions is pregnant with the potential for impasse; the Task Force, in my opinion, has wisely avoided this debate, while making it clear that competence in the tasks of self-regulation is key to maintaining independence. Ontario can learn from challenges to self-regulation, for example, in Great Britain. During his recent visit to Ontario, the CEO and Registrar of the General Medical Council in Britain, Finlay Scott, reported that doctors in Britain have come perilously close to losing the privilege of self-regulation, noting that "We were so concentrated on our processes, that we lost sight of our purpose – protecting patients". The Law Society of Upper Canada Strategic Plan, tabled June, 2000, adopts a philosophy of public protection, which all regulating bodies would be wise to adopt and implement, to ensure standards are set and maintained which are worthy of public trust in continuing self-regulation.

The Task Force has identified certain processes that are unwieldy, unnecessary, and have had the effect of doubly victimizing the victim. As someone who has sat on a number of disciplinary tribunals, including under the Police Act, I support the recommendations of the Task Force Report, which have, properly, in my judgment, recommended reliance on standards in the Statutory Powers Procedure Act that are common and appropriate to non-judicial institutions such as self-regulating professions. Unfortunately, the importation of processes and standards from the Criminal Courts to what are, essentially, quasi-judicial or administrative disciplinary bodies, has been costly, and shown to be harmful, serving only to perpetuate the status quo.

As a tax payer and citizen of this Province, I strongly support the recommendations of the Task Force for the creation of a Public Access Centre, a central service agency which will assume responsibility for all regulated health professions and their colleges in the provision of public information, training and education in sexual abuse prevention, and acceptance and processing of complaints about sexual abuse by members of the regulated health professions through to completion of the complaints process. First, this would eliminate the current duplication of resources, whereby each of

21 colleges attempts to respond to the complex dynamics of sexual abuse, with differing resources, and differing expertise. More important than the obvious benefits to the colleges and their health professionals, is the benefit to patients, and the public: staff of a central service agency will have the necessary high level of training in the issues of sexual abuse, and will bring a consistent, dedicated focus to prevention, detection and correction. This concentration of highly trained people will be, in my judgment, a powerful catalyst for the changes needed throughout the system. In relatively short order, capacity would exist to build truly effective responses to harms which have to date eluded successful solutions, notwithstanding the best efforts of the Province and the colleges.

Most important, is the fact that all of these solutions proposed by the Special Task Force are possible - NOW – Ontario's leadership in this area can continue, and the intention of the *Regulated Health Professions Act* can be fully realized.

Considerable support will be needed to bring the recommendations of this Report to life. I urge that those with power in the political, medical, legal and educational fields make that support a priority, to ensure that every patient will have secured the right to safety in relationships with Health Professionals and that the Health Professions can keep the public trust through effective self regulation.

Jane Pepino

Eleven Questions for the Task Force

The Minister of Health and Long-Term Care (the Minister) and her advisory council, HPRAC, asked the Members of the Special Task Force to answer 10 questions about the impact of sexual abuse complaints and discipline processes on patients. We added the last question on education and training. We have endeavoured to prepare our *Advice and Recommendations* by paying particular attention to the information that came to us from patients, in response to these 11 questions. Chapters 1 and 2 deal with aspects of all 11 questions.

CHAPTER 3

1. How can the complaints and discipline processes for professional misconduct of a sexual nature be made more sensitive and respectful towards complainants? (HPRAC)
2. Should regulated health professionals be required to disclose the name of the affected patient/client in a mandatory report? (HPRAC)

CHAPTER 4

3. How do the Colleges' complaints and disciplines processes impact on individuals who complain of being sexually abused by members? (the Minister)
4. What would be the most appropriate status for the complainant throughout the complaints and discipline processes? (the Minister)

CHAPTER 5

5. What penalties have been applied when a member claims that sexual relations between the member and the client\patient are consensual? (Minister)
6. Do individuals who have been sexually abused by members feel that the penalties imposed by the College Committees and the Courts are fair and just? (the Minister)
7. Are the mandatory revocation penalty provisions effective or should the mandatory provisions be amended? (the Minister)

CHAPTER 6

8. Under what circumstances is mediation being used by Colleges in the complaints and discipline process related to sexual abuse? Are complainants satisfied with the mediation process? (the Minister)
9. What is the experience of complainants in accessing funding for therapy or counselling from Colleges? (HPRAC)

CHAPTER 7

10. How can the public be better informed about (a) where to file a complaint about professional misconduct of a sexual nature by a regulated health professional and (b) Colleges' complaints and discipline procedures? (HPRAC)
11. How can training and education be improved to reach the goal of eliminating sexual abuse of patients by health professionals? (Task Force)

Executive Summary

OF THE FINAL REPORT OF THE SPECIAL TASK FORCE ON SEXUAL ABUSE OF PATIENTS

"I was put on hold so many times and was switched from person to person so many times that I felt like giving up."

OUR MANDATE

Our report to the Honourable Elizabeth Witmer, Ontario's Minister of Health and Long-Term Care and to Dr. Rob Alder, the chair of her advisory council, the Health Professions Regulatory Advisory Council ("HPRAC") contains extensive quotes from patients like the one above because Ministry correspondence with our Task Force chair, Marilou McPhedran, asked us "to hold public and private hearings and receive submissions from members of the public in order to provide advice and recommendations to the Minister on the public's experience with colleges' complaints and discipline process in cases of a sexual nature."

In our announcements and correspondence we described our mandate as:

"To conduct an independent inquiry into the experiences of patients and members of the public on the subject of sexual abuse by regulated health professionals in Ontario in order to provide Advice and Recommendations to the Health Professions Regulatory Advisory Council and the Minister of Health and Long-Term Care as part of the five year review of the *Regulated Health Professions Act*."

Nine years ago, we were members of the task force commissioned by the College of Physicians and Surgeons of Ontario (CPSO) to prepare an independent report on the sexual abuse of patients. The *Regulated Health Professions Act* (*RHPA*) was subsequently amended to include Bill 100, which incorporated some of our recommendations and established new processes and standards for responding to and preventing sexual abuse.

We have had less time, a larger mandate and fewer resources to complete this report and no access to college records. Our only access to patient files has been through patients themselves. When we listened to what patients told us, we felt that time had stood still during the nine years since we submitted our first report. Very little has improved and the kinds of difficulties that patients experience in trying to access self-regulation processes remain much the same.

As a Task Force, we need to situate our assessment of the extent to which these processes operate in the best interest of the public by noting that, although the review being conducted by The Health Professions Regulatory Advisory Council (HPRAC) is much needed, it is described as "a five year review of the *RHPA*." Yet many of the colleges report that they have not decided cases under the *RHPA*. The fact is, even today, many sexual abuse complaints are still being processed under the 'old' Health Disciplines Act because the alleged offence(s) occurred before the sexual abuse amendments in Bill 100 became operative.

We believe that college registrars, staff members, governing councils, complaints and discipline committees and college legal counsel—who all share responsibility for patient outcomes—could have chosen to exercise their discretion to apply standards consistent with the *RHPA* more often in sexual abuse cases that have occurred since l994, even though they were not legally obligated to do so.

Upholding the Zero Tolerance Standard

> *"How is it possible that professionals who are sworn to serve and protect the public, can sexually abuse their patients? That there is a single case of sexual abuse by a health care professional is wrong; that there are thousands is nearly impossible to believe, but that there are few prosecutions and no protection by the colleges is astounding."*

The philosophy of Zero Tolerance of sexual abuse of patients must remain the guiding principle for the development, implementation, and evaluation of all policies and practices designed to stop sexual abuse by health professionals.

Summary of Patient Reports

We have learned a great deal, as we did in our 1991 investigation and report, from the real experts on the dynamics of sexual abuse—those who have had to learn how to survive the experience. We are honoured by the trust they placed in us and will continue to work as individuals to bring greater fairness to the regulatory college, university, legal system and institutional processes that so often undermine patients who have been sexually abused.

Our Task Force received over 60 reports of sexual abuse between February and July of this year, and some additional reports that did not involve sexual abuse. We were able to follow up with 57 people who complained of having been sexually abused and we met in person with 22 of them. Of the 57 reports of sexual abuse, about 80% came from or on behalf of women (46 reports) and 20% were submitted by men (11 reports). Almost 9 % of the reports concerned sexual abuse by female health professionals. Three men and two women reported sexual abuse by female health professionals. Her parents represented one young woman who was paralysed and could not speak. A speech language pathologist also told us of a number of her speech-disabled patients who had been sexually exploited by the health professionals on whom they were dependent. A number of patients self-identified as members of minority groups, although we did not ask patients to provide this type of information. Five patients reported that they were less than 14 years of age when they were abused.

The time and money required to do an optimal gathering of information in this large province were not available to us. Indeed, sexual abuse of patients would have virtually disappeared as an issue, without media coverage of specific cases as 'news'. Accountability of government and college systems is definitely in the public interest, but the resources to keep these systems accountable are relatively limited. Patients and their advocates, in comparison to the government and the colleges, currently have no financial resources to develop coordinated counter-measures to the sexual abuse of patients.

There is an understandable need to perceive all health care providers as wise, safe and trustworthy even when some have none of these characteristics. We are often more comfortable in the state of denial widely shared in our community at large—that sexual abuse of patients happens somewhere else and that it is not pervasive.

Who Counts?

Patients who are sexually abused represent a limited but very significant percentage of patients in Ontario. Health professionals who sexually abuse their patients are also a small minority of the members of their respective professions. But the reach of the problems caused by the sexual abuse of patients is vast. There are 10 million people in Ontario. Assuming about 8 million are represented in the recent survey conducted for HPRAC, (see Chapter 2 of this report) because children were not included, it is not unreasonable to estimate that well over 200,000 Ontarians, taking into account the likelihood of under reporting have experienced sexual abuse at the hands of health professionals during the five years that the *RHPA* has been in force.

We were informed by HPRAC, in a communication from the chair in August of this year, that the "study in question found that one per cent of respondents (men and women) had experienced sexual contact/touching by a health professional and two per cent had experienced inappropriate behaviour/remarks from 1994 to 1999 – rates lower than the 1991 study among women alone." It is our advice to proceed very cautiously in reaching a conclusion about lower prevalence of sexual abuse of patients by the full range of health professionals, based on the HPRAC survey mentioned above.

The nature of this kind of sexual abuse works against uncovering the truth and eradicating the abuse. Society must recognise this in designing or evaluating any system to address it.

The data compel us to say that sexual abuse by health professionals remains an important public safety problem; magnified when we consider the specific impact and severity of sexual abuse due to breach of trust. We must no longer deny the seriousness and prevalence of sexual abuse of patients and the inadequacy of our responses.

The Need for a Patients' Bill of Rights in Ontario

"The College's complaints and discipline process seems not to act until the College is forced, by law, thus leaving the victim who brings forth the complaint left hanging with nowhere to go."

Patients who report sexual abuse can become pawns in a complicated, expensive process, wherein lawyers and other professionals are paid to operate processes that have not been designed with the needs of patients as a priority. The difficulty that many patients have in reporting abuse is often compounded by their personal and individual circumstances, as a victim. To be effective, in the public interest, the legislation governing health professionals and institutions that provide health services to patients, such as the *RHPA* and the Ontario Hospitals Act, needs to be amended to require all regulated health professionals and all health care institutions to post the Patients' Bill of Rights and up-to- date contact information wherever health professionals are offering their services.

" I believe that the college used its legislative mandate and policies to provide the illusion of working in the public's interest and of providing much needed support and assistance to victims. The college repeatedly missed legislative and internal policy timelines as well as reneging on other commitments made to the victim."

A New Model for Self-Regulation

All of our recommendations have been developed through the lens of public safety and equity. We recommend amending the *RHPA* to create a new central service agency, the "Public Access Centre" (PAC), in response to information received from patients and their advocates, the colleges and HPRAC itself. We are convinced that 'leaving things as they are' will not improve the efficacy of self-regulation nor serve the public interest. We believe that if self-regulation is to merit continued authority and credibility, the public's first point of contact in cases of sexual abuse, and continuing service and support to complainants, can no longer be left with 21 separate colleges — some of which have no previous experience in this aspect of self regulation. In our model, the Public Access Centre ("PAC") would be responsible for receiving, investigating and deciding whether sexual abuse complaints should go on to a disciplinary hearing. There would no longer be Complaints Committees in the colleges made up only of members of that particular college council. The PAC would be responsible for the initial investigations of sexual abuse complaints, empaneling the complaints committees by drawing from a much larger, interdisciplinary pool of public and health professional members than is currently available in the separate colleges. Once a Complaints Committee has concluded that a sexual abuse complaint should go on to a disciplinary hearing, then the member will be "judged by peers" and public members on the Discipline Committee of the member's college, much as happens now, thus preserving the essential principle of self regulation.

It is clear from our discussions that, while the staffs of some regulatory bodies possess a good understanding of the dynamics of sexual abuse, they may not fully appreciate the power differentials involved or the degree of damage that can be inflicted upon those who are the victims of sexual abuse. It is also clear from the outrage and pain expressed by complainants that the staff of some colleges— up to and including registrars—may lack the training or the empathy necessary to help sexual abuse survivors cope with what has happened to them.

The Public Access Centre that we recommend establishing would be better positioned to deliver consistent, responsive education and training as a top priority, in co-operation with the colleges. It should be noted that, for more than five years now, the colleges have had the statutory obligation to provide training and education through the establishment of Patients Relations Committees that are required to develop measures for preventing or dealing with sexual abuse including: educational requirements for members; guidelines for the conduct of members with their patients; training for the College's staff; and the provision of information to the public.

Unfortunately, we found that the implementation of this statutory obligation has been inconsistent. In one of the largest colleges, the Patients Relations Committee was fully activated only last year. We recommend that the Patients Relations Committees continue to be responsible, internal to each college, for facilitating the cooperation and effectiveness of college staff in the implementation of the responsibilities which the PAC will undertake: access, education, training and investigation to completion of the complaints committee stage in the process.

IMPLEMENTATION STRATEGIES

The Task Force recommends establishing the Regulated Health Professions Public Access Centre (PAC) and an HPRAC Monitoring Team as the two new mechanisms for ensuring implementation. We recommend that the PAC and the HPRAC Monitoring Team be joint ventures with clear obligations to the public, including the publication of annual reports. Our Task Force explicitly advises against any new mechanism that is based solely within the Ministry of Health and Long-Term Care. It is crucial that the changes to the self-regulatory system be transparent and accountable through the "check and balance" of shared responsibility and accountability to the public interest in safety and equity.

Under the current *RHPA* process, when patients receive word from a college that their complaints have been turned away after an initial investigation, they cannot appeal college decisions to the courts, as a health professional can. Patients are given 30 days in which to file an appeal with the Health Professions Appeal and Review Board (HPARB). Some patients told us that the HPARB was a very helpful countermeasure to delays by colleges, but the majority of those who told us of their experiences with HPARB reported delays and treatment that they considered disrespectful and insensitive.

The Health Professions Appeal and Review Board needs to be appropriately resourced to clear its backlog and there will need to be closer liaison with the new Public Access Centre and the HPRAC Monitoring Team to ensure that HPARB fulfills its mandate.

In Chapters 3 and 4, we discuss the urgent need to amend the *RHPA* to give patients full party status in the complaints and discipline processes. The Government of Ontario contributes to the costs of legal representation for doctors; the same principle should apply to patients.

ELEVEN QUESTIONS AND ANSWERS

In the section just before this executive summary, 11 questions are listed. The Minister and her advisory council, HPRAC, asked us to answer 10 questions about the impact of the sexual abuse complaints and discipline processes on patients. These 10 questions raise issues such as confidentiality, rules of procedure and evidence at disciplinary hearings, penalties such as mandatory revocation upon a finding of sexual abuse, use of alternative dispute resolution and mediation in sexual abuse cases, access to therapy for patients who have been sexually abused, access to information. We added the last question on education and training. Members of the Task Force have endeavoured to prepare our Advice and Recommendations by paying particular attention to the information that came to us from patients, in response to these 11 questions. The full list of the 34 Recommendations that we have made follows this executive summary.

CONCLUSION

Ontario has been recognised deservedly as an international leader in this complex field. Progress has been made over the past nine years, but equitable remedies have not flowed to many patients who have been sexually abused. The Recommendations in this Report have been designed to shift resources to a more co-operative and efficient patient-centred model of self-regulation by health professionals – as the means of implementing the standard of Zero Tolerance of sexual abuse of patients. Meeting this standard will benefit health professionals and patients through effective self-regulation and thereby honour the public trust.

Recommendations

CHAPTER 1 – LISTENING TO PATIENTS

ENACTING A PATIENTS' BILL OF RIGHTS

RECOMMENDATION 1

1.0 A Patients' Bill of Rights should immediately be developed by the Ontario Ministry of Health and Long-Term Care, after consultations including patients' advocacy groups and colleges, as an amendment to the *Regulated Health Professions Act* ("*RHPA*") of Ontario, to be made easily available through the Ministry, the Colleges and the Government of Ontario public information systems. The Patients' Bill of Rights must include the definition of sexual abuse in the *RHPA*, a toll free telephone information number, and give clear and accurate information to the public about how to make sexual abuse complaints to the Public Access Centre, which we recommend be established immediately.

Members of the regulated health professions are to be legally obliged to ensure that the Patients' Bill of Rights is posted in every location where their health services are offered, including institutions where they are employed. Removal or failure to post the Patients' Bill of Rights will incur a penalty under the *RHPA*, enforceable by the member's College.

1.1 It is further recommended that the legislation governing health professionals and institutions in Ontario that provide care to patients, such as the *RHPA* and the Ontario Hospitals Act be amended to require all regulated health professionals and all chief executive officers of health care facilities to post the Patients' Bill of Rights and current contact information in high visibility locations wherever health professionals are offering their services.

CHAPTER 2 – THROUGH THE LENS OF PUBLIC SAFETY AND EQUITY

UPHOLDING THE ZERO TOLERANCE STANDARD

RECOMMENDATION 2

2.0 The philosophy of Zero Tolerance of sexual abuse of patients must remain the guiding principle for the development, implementation, and evaluation of all policies and practices designed to stop sexual abuse by health professionals.

The Ministry of Health and Long-Term Care, the Health Professions Regulatory Advisory Council, the Federation of Health Regulatory Colleges, individual colleges and health care facilities should follow the action of the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association in formally adopting the philosophy of Zero Tolerance to guide implementation of policies and practices protecting the public through self regulation. Any review of the *Regulated Health Professions Act* should specifically evaluate implementation of this standard for protection of the public.

THE NEW "PUBLIC ACCESS CENTRE"

RECOMMENDATION 3

3.0 The *Regulated Health Professions Act* ("*RHPA*") should be amended to create a central service agency - the Regulated Health Professions Public Access Centre ("PAC") - which will share some responsibility for processing inquiries and complaints about sexual abuse by regulated health professions with their colleges by providing:

a) the investigation of patients' complaints under the *RHPA* from first contact through to determination by Complaints Committees as to whether the complaint is to proceed to a disciplinary panel under the *RHPA*;

b) in an expeditious manner, the processing of complaints of sexual abuse including where civil/criminal proceedings have also been initiated against the health care professional;

c) information to patients and other members of the public including access to a provincial data base on sexual abuse complaints and cases involving regulated health professionals in Ontario, with linkage to national and international data programs;

d) support and advocacy services for patients who report experiences of sexual abuse by regulated and unregulated health professionals in Ontario, including some funding of patients' advocacy groups and patients' advocates;

e) pre-professional and continuing education and training programs, designed to eliminate sexual abuse of patients, in cooperation with health regulatory colleges, post secondary institutions and advocacy groups;

f) training of members of governing councils of the colleges under the *RHPA* as a prerequisite for eligibility to decide discipline cases on charges of sexual abuse;

g) training of staff of colleges, including legal staff and retained counsel, in the dynamics and impact of sexual abuse of patients to ensure consistent and relevant hiring criteria and performance standards for college personnel dealing with sexual abuse of patients;

ANNUAL REPORTS FOR THE PUBLIC RECORD BY COLLEGES AND HPRAC

RECOMMENDATION 4.0

4.0 The *RHPA* be amended to include the requirement that every college shall make a public annual report to the Minister of Health of any complaints received, concerning the sexual abuse of patients by members or former members of the college, including a summary of the timeline and description of actions taken by the college in disciplinary procedures.

4.1 The HPRAC Monitoring Team, to be established pursuant to Recommendation 7.0, should design the template for this annual report, in consultation with patients' advocacy groups, the colleges and the Public Access Centre. This annual report should include:

(a) the number of complaints of sexual abuse received during the calendar year;

(b) the date each complaint was received;

(c) a description of the complaint, decisions with respect to the complaint and the date of any decision;

(d) the decision of the Discipline Committee, including any penalty imposed;

(e) the date and outcome of any appeal;

(f) any other complaints related to *RHPA* provisions to stop sexual abuse of patients, such as posting of the Patients' Bill of Rights in every location where members offer health services;

(g) an explanation and description of the time taken and the process followed, including whether the member's identifying information is available to the public, if the complaint did not go to a discipline hearing; and

(h) specific details as to any fines or penalties imposed as prescribed by the Health Professions Procedural Code ("*RHPA Code*").

RECOMMENDATION 5

5.0 Following every determination and resolution of a complaint about sexual abuse, every college is to ensure an evaluation form is sent to every patient involved in the process, including a pre-paid return envelope addressed to the HPRAC Monitoring Team.

RECOMMENDATION 6

6.0 The HPRAC Monitoring Team should be required to make an annual report to HPRAC and the Minister for the public record, including a detailed summary of the patient evaluations in the preceding recommendation and suggestions for more effective procedures in the public interest.

CHAPTER 3 - SELF REGULATION IN THE PUBLIC INTEREST

THE NEW HPRAC MONITORING TEAM AS A CATALYST FOR IMPLEMENTATION

RECOMMENDATION 7.0

7.0 HPRAC should establish a "Monitoring Team" chaired by a designate of HPRAC, to supervise and facilitate the development and implementation of any initiatives to deal with sexual abuse by health professionals, including recommendations that flow from this report, with a renewable term of five years; membership to include Ministry of Health appointees at least at the director level in the ministry, at least one member of the Special Task Force, two survivor/advocates working in the field of abuse prevention and/or victim support, and at least one executive officer of the PAC, with remuneration at least at the level of HPRAC members.

Recommendation 8.0

8.0 For the initial five year term of the HPRAC Monitoring Team, it will commission an empirical study to determine how many mandatory reports have been made since 1999, what was done by the college receiving the report, whether any further reports or complaints about the member have been received and what actions have been taken. Details as to best practices among colleges in Ontario and in other jurisdictions, especially Prince Edward Island and New Brunswick, are to be included with recommendations for ways to increase responsiveness to patient complaints in the interest of public safety.

Identifying Patients

Recommendation 9.0

9.0 The existing protection in section 85.3(4) of the *RHPA* Code must be upheld to ensure that a reporting member does not give the name of the patient complainant unless the member has the express, written consent of the patient.

Immediate Reporting

Recommendation 10.0

10.0 Section 85.3(2) of the *RHPA* Code should be amended to the effect that mandatory reports should be made forthwith rather than within a 30-day period and that such a report should be immediately reviewed by the PAC, with an investigation triggered upon the receipt of any report which prompts reasonable suspicion that the member poses a risk of harm to patients, or upon the receipt of two reports of sexual abuse by a member.

Enforcement of Penalty for Not Reporting

Recommendation 11.0

11.0 Colleges must enforce the penalties specified in section 93(4) of the Code of a maximum fine of $25 000 on health professionals who fail to make a mandatory report of sexual abuse.

Health Professions Appeal and Review Board

Recommendation 12.0

12.0 The *RHPA* Code should be amended to include a provision that requires the Health Professions Appeal and Review Board, when reviewing a decision of a Complaints Committee Panel, to render a decision within 120 days of receiving the request for review.

Evidentiary rules at Discipline Hearings

Recommendation 13.0

13.0 Section 49 of the *RHPA* Code should be repealed and a new provision be added that states that the evidentiary rules governing college and PAC complaints and discipline hearings are governed by the Statutory Powers Procedure Act.

RECOMMENDATION 14.0

14.0 Section 36 (3) of the *RHPA* should be amended so that evidence on the findings, orders or decisions in disciplinary proceedings under the *RHPA* are admissible in civil proceedings.

FINES AND FUNDING FOR THERAPY

RECOMMENDATION 15.0

15.0 Provincial rules and legislation should be amended to ensure that any fines imposed on a member for the sexual abuse of a patient should be designated as a separate fund under the jurisdiction of the Public Access Centre, to be used for support to patients, including therapy and counselling for eligible patients.

15.1 Section 85.7 (4) and (10) of the *RHPA* Code should be amended so that interim funding for patients' therapy can be provided prior to the hearing stage, where the PAC determines that it is a meritorious claim.

CHAPTER 4 – IMPACT OF COLLEGE PROCESSES ON PATIENTS

MOST APPROPRIATE COMPLAINANT STATUS AND SUPPORT IN HEARINGS

RECOMMENDATION 16.0

16.0 It is recommended that the *RHPA* Code be amended to include the following provisions in sexual abuse cases:

a) all complainants should have the right to participate in the proceedings of any complaints or disciplinary hearings, as a full party;

b) all complainants should have the right to a support person of her choice at the expense of the PAC and the colleges, at all stages of the investigation, complaints process, and disciplinary hearings;

c) all complainants should have a right to testify behind a screen, by closed circuit television, or similar device that allows the complainant not to see an adverse party, if it is likely to help the complainant to give complete and accurate testimony or if it is in the best interests of the complainant;

d) all complainants should have the opportunity, in accordance with current *RHPA* provisions, where the member is found guilty, to submit a victim impact statement and not to be cross-examined on that statement, such statement to be taken into account in the assessment of a remedy or penalty;

e) A videotape of an interview with the complainant may be admitted in evidence if the complainant, while testifying, adopts the content of the videotape; and

f) Under no circumstances, can the alleged perpetrator of the sexual abuse personally cross-examine the complainant.

EXPERT WITNESSES

RECOMMENDATION 17.0

17.0 The PAC and colleges must develop criteria for selection of experts to present evidence at complaints, discipline and reinstatement proceedings, to ensure that expert witnesses have clearly demonstrated expertise in the dynamics and impact of sexual abuse by health care professionals.

Fast Tracking Sexual Abuse Cases

Recommendation 18.0

18.0 All discipline cases of sexual abuse by health care professionals should be given priority and fast tracked by the colleges.

CHAPTER 5 – Deterrents and Penalties

Sexual Contact Guidelines

Recommendation 19.0

19.0 The *RHPA* already specifies no sexual contact between members and their patients, but it should be amended to specify clear boundaries for sexual contact between members and their former patients, as follows:

a) that a member must not have sexual contact with a former patient for a period of two years following the date of last professional contact with that patient, whether or not the member has formally terminated the professional relationship, provided that the member should never have sexual contact in cases where the former patient

  i) was a minor during the period of professional care; or

  ii) was suffering a judgment impairing disorder during the period of professional care; and

b) that a member must never have sexual contact with a former patient when the professional relationship was psychotherapeutic in nature.

Penalties: Zero Tolerance Principles

Recommendation 20.0

20.0 The *RHPA* Code should be amended so that the penalties imposed in cases of sexual abuse are consistent with the Zero Tolerance standard and act as a deterrent to ensure that the public is protected. To this end, the following principles should be in amendments to the *RHPA Code* to guide in the determination of penalties:

a) specific deterrence of the member of engaging in further sexual abuse;

b) general deterrence of other members of the profession;

c) denunciation by society of the conduct; and

d) the need to maintain the public's confidence in the integrity of each profession's ability to properly supervise the conduct of its members.

Mandatory Revocation where Recurrent Pattern

Recommendation 21.0

21.0 The *RHPA* Code should be amended to include mandatory revocation of the certificate of registration of a member who has been found guilty of a recurrent pattern of sexual abuse under section 1(3) (b) or (c) for a period of time to be stipulated by the discipline panel.

CHAPTER 6 – MEDIATION, SUPPORT AND THERAPY FOR PATIENTS

FUNDING FOR THERAPY EXTENDED

RECOMMENDATION 22.0

22.0 A regulation pursuant to section 85.7 of the *RHPA Code* should be made to clarify that funds are to be provided to the patient / complainant in a sexual abuse complaint to cover the cost of medications, childcare, and reasonable travel/accommodation expenses associated with accessing therapy related to the sexual abuse.

RECOMMENDATION 23.0

23.0 The *RHPA Code* should be amended to clarify that funding for therapy can be retroactive so that the complainant may be compensated for therapy received prior to the hearing for problems arising from sexual abuse by a member; and to ensure that the proceeds from fines for sexual abuse are directed to funding therapy for victims.

RECOMMENDATION 24.0

24.0 A regulation pursuant to the *RHPA* should stipulate that a patient is also eligible for funding for therapy or counselling if:

a) there is an admission made by a member in a statement to the College that the member sexually abused the patient;

b) the member has been convicted under the Criminal Code of Canada of sexually assaulting a person while that person was a patient of the member; or

c) the Public Access Centre or whatever agency is responsible for a decision, determines that there is sufficient evidence to support a reasonable belief that the patient was sexually abused by a member.

NO USE OF MEDIATION / ADR

RECOMMENDATION 25.0

25.0 The *RHPA Code* should be amended to state that any procedures considered to be Alternative Dispute Resolution or Mediation are not to be used to attempt to resolve complaints of sexual abuse.

CHAPTER 7 – INFORMATION, EDUCATION AND TRAINING

INFORMATION ACCESSIBLE ON THE PUBLIC RECORD OF COLLEGES

RECOMMENDATION 26.0

26.0 Section 23(3)3.1 of the *RHPA Code* should be amended to require that every College Register includes disciplinary decisions in which the member was found to have committed an act of sexual abuse as defined in section 1(3)(c) [behaviour and gestures] as well as 1(3) (a) [physical sexual relations] and (b) [touching of a sexual nature] of the Code and that staff of colleges are clearly obliged to inform anyone who inquires as to the nature of the complaint.

Recommendation 27.0

27.0 Section 23(2) of the *RHPA Code* should be amended to ensure that College Registers contain any stipulations or programs imposed on a member related to any complaint of sexual abuse of a patient, with a notation on whether the requirements were met.

Recommendation 28.0

28.0 The *RHPA* should be amended to require each college to publish and maintain on the public record all disciplinary panel decisions, or determinations through any other means, including suspension or resignation of the member, related to sexual abuse complaints processed by that college.

Recommendation 29.0

29.0 Applications for a certificate of registration or for reinstatement of a certificate to any college under the *RHPA* are to require verification as to good character, including sworn statements as to: previous convictions or charges of a criminal nature, any civil findings where the member has been a party in a lawsuit involving sexual abuse or harassment, and reasons given for resignation or suspension if the member has resigned or was suspended from a college or any other health profession in any other jurisdiction.

29.1 Applications for reinstatement must include reference to any conditions placed by the college, which the health professional was to meet, and evidence that the conditions have been met, prior to making the application.

Provincial, National and International Database Access

Recommendation 30.0

30.0 The *RHPA* should be amended to ensure that, once a finding of guilt in a sexual abuse complaint is made in a discipline hearing or determination of any kind, including resignation, colleges are legally obliged to inform all other licensing authorities in Canada and to keep written records verifying notification.

Recommendation 31.0

31.0 The Ministry of Health and Long-Term Care should initiate joint and reciprocal ventures to establish and maintain both a national and international database of sexual abuse offenders who are regulated health care professionals to inform and be informed by health professional licensing authorities and health care institutions in other jurisdictions.

Protection from Sexual Abuse by Unregulated Health Practitioners

Recommendation 32.0

32.0 The Ministry of Health and Long-Term Care and the HPRAC Monitoring Team, in consultation with the Public Access Centre and the colleges, should commission research to determine the most effective legislative means for creating and maintaining a public record listing unregulated health practitioners who have previously lost their licences due to sexual abuse of patients.

Education of Health Professionals

Recommendation 33.0

33.0 HPRAC should ensure that its current review of all the Patients Relations Programs of the colleges includes analysis of confidential evaluations, by first year graduates in each regulated health profession and by patients and patients' advocacy groups, of the following measures required under section 84 of the *RHPA Code*:

a) educational requirements;

b) guidelines members are to follow when dealing with patients; and

d) provision of information to the public.

Recommendation 34.0

34.0 The Ministry of Health and Long-Term Care, in co-operation with the Public Access Centre, health regulatory colleges, post secondary institutions and patients' advocacy groups, should immediately initiate the following changes:

a) creation of mandatory course materials that include the perspectives of patients, on preventing sexual abuse of patients, for every level of professional training and continuing education applicable to regulated health professions in Ontario,

b) require that colleges ensure that all applicants for registration in Ontario are tested on their knowledge of the dynamics of sexual abuse of patients and their responsibilities as regulated health professionals,

c) require that the Public Access Centre, in co-operation with the colleges and patients' advocacy groups, prepare, publish, disseminate and update guidelines for the public and health professionals to prevent sexual abuse of patients.

Who we are and why we did this

Left to Right: Karen Brown, Marilou McPhedran, Roz Roach, Briar Long, Pat Marshall, Harvey Armstrong and Ronda Bessner.

In 1991, members of this current task force worked together on a task force commissioned by the College of Physicians and Surgeons of Ontario to prepare an independent report on the sexual abuse of patients by doctors.

The recommendations contained in our 1991 report led to the enactment of Bill 100 amendments to the *Regulated Health Professions Act*, which, for the first time, defined sexual abuse of patients and specified a procedural code for the 23 professions that are governed under the Act. Our 1991 recommendations are in Appendix V of this report.

In November 1999, at the request of Marilou McPhedran, who chaired the 1991 task force, we met with the Honourable Elizabeth Witmer, Minister of Health and Long Term Care, to discuss our concerns about implementation of the provisions in the Act intended to protect patients from sexual abuse.

In January 2000, the Minister asked that her advisory council (the *Health Professions Regulatory Advisory Council*, or *HPRAC*) appoint us as the current Special Task Force on Sexual Abuse of Patients by Health Professionals in Ontario (STF) so that we could prepare a new independent report.

It was agreed that this, our final report—which contains advice and recommendations concerning the impact of the *RHPA* on patients who have experienced sexual abuse by health professionals—would be released to the general public as soon as HPRAC delivered its five year review of the *Regulated Health Professions Act* to the Minister.

The task force members bring a wide range of skills and perspectives to work as an interdisciplinary team. This report was written by consensus, with no dissension concerning our final recommendations.

Marilou McPhedran, the task force chair, is a lawyer who provides strategic counsel in health and human rights. She directs the International Women's Rights Project at York University and is co-founder of a number of non-profit women's organizations that specialise in systemic change.

Harvey Armstrong, who has more than 30 years experience as a child and adolescent psychiatrist working with underserved and underprivileged clients, has most recently worked with parents of antisocial youth who refuse intervention.

Briar Long is a medical doctor in her third year as a psychiatric resident, who served as coordinator of the original task force in 1991 before going to medical school at McMaster University.

Pat Marshall, who has worked nationally and internationally for over 20 years to promote equality and safety for women and children, was founding executive director of METRAC (Metro Action Committee on Violence Against Women) and national co-chair of the Canadian Panel on Violence against Women.

Roz Roach, who has a nursing degree and doctorate, is the founder of the Women's Healing Centre and is the executive director of the Emily Stowe Shelter, which serves women and children from a diverse urban population.

Ronda Bessner, is the Expert Advisor to this Special Task Force, a legal and policy consultant who teaches at the University of Toronto Law School and an author who has published extensively in the field of sexual abuse, including reports for the Ontario Law Reform Commission and Justice Canada.

Our primary motivation for agreeing to work under the pressured conditions of this 'revived' task force came from the many patients who sought us out over the past nine years to express their anguish and concern about the damage they continued to experience as a result of sexual abuse by health professionals.

We are extremely grateful for the extraordinary efforts, under difficult circumstances, of the many who—because of their concern for patients and their desire to improve the regulatory system—devoted far more time and work to this project than could be compensated.

We would particularly like to thank the following experts: **Dr. Earl Berger, Mary Lou Fassel, Dr. Judith Herman, Dr. Susan Penfold, Dr. Gary Schoener, Susan Vella,** and **every patient** who taught us so much.

N. Jane Pepino and the **Ontario Women's Health Council** facilitated a wider distribution of this report, including to hundreds of libraries in Ontario.

We are likewise grateful to task force coordinator **Karen Brown**; legal researchers **Kathleen Gallivan, Angela Green-Ingham, Valerie Markidis, Andrea Unikowsky** and **Dawn Devoe**. We appreciate the efforts of our editor, **Jon Boynton**, our report designer, **Martha Newbigging**, **Ministry of Health and Long Term Care** officials, members and staff of the **Health Professions Regulatory Advisory Council** and last, but by no means least, **Valerie Markidis** and **Negar Mahdavian** who worked nights and weekends with the chair to help complete this report.

When you read this report, the Special Task Force on Sexual Abuse of Patients will have disbanded, but we will not stop seeking ways to keep this issue as a priority on the public agenda. We believe that this independent report, released in full to the public, will continue to be useful as a guide to the achievable - using the full potential of the *Regulated Health Professions Act* to implement processes that will eradicate the sexual abuse of patients.

Introduction

P. SUSAN PENFOLD, MB, FRCP(C)

Professor, Department of Psychiatry, University of British Columbia. Author of Sexual Abuse by Health Professionals: a Personal Search for Meaning and Healing.

Once again Ontario has led the way and created a special task force to examine the continued occurrence of sexual abuse by health professionals. Despite much public discussion in the early nineties, tougher legislation, and widespread education of professionals, an immense challenge remains. The 1999 survey in Ontario reported that one percent of adults – thousands of patients - said that they had experienced sexual contact with a health professional within the last five years. Yet very few made complaints.

What is maintaining this silence and what can be done? Why do consumers view current college processes as a vastly unequal playing field where professionals are protected and victims discouraged, disbelieved and disempowered? Why do many health professionals consider the statistics overblown and false complaints abundant?

My own experiences and that of other survivors shows that many obstacles exist for the victim, and that breaking the silence is made difficult by a number of factors. These include survivors' feelings, community attitudes and lack of support, the self-protective stance of the health professions, and the idiosyncrasies of the legal system.

Emotions that obstruct survivors' desire to make a complaint include shame, self-doubt and fear. The problems created by the sexual abuse, including pervasive self-doubt and shame and self-blame can make a complaint or public disclosure impossible. What will spouses, children, relatives, friends, and workmates think of them? Will the imperfections of their whole life be examined and their humiliating sexual secrets made public? Some, feeling angry and betrayed, are reluctant to trust boards of inquiry and committees of professionals that work in the same field. Others, still struggling with guilt about their own possible complicity and lingering positive feelings about the health professional, are hesitant to take the step that could hurt the offending health professional or damage his or her career.

On the whole, our society is not particularly sympathetic to victims, and people often assume that victims cause and deserve their problems. Sympathy for child victims of sexual abuse is more readily evoked, but adolescents and adults may have little credibility. When society lacks an understanding of the fiduciary duty of health professionals, or fails to recognize the enormous power imbalance between health professional and patient, misinterpretations, biases and harsh judgments abound. For instance, the abuse is reinterpreted as "consensual" - an "affair". The victim may be thought to have seduced the health professional. The character of the victim is often maligned and he or she is seen as a dangerous, vindictive, seductive, manipulative person who has outwitted and trapped the health professional in a sexual relationship, or grossly exaggerated or lied about an appropriate encounter.

Health professionals rely on rationalizations and assumptions to allow them to maintain certain beliefs: that sexual abuse of patients no longer exists or is being greatly exaggerated, causing widespread and unnecessary restrictions on professional practice; that they are able to police themselves; that victims who complain are treated with dignity and respect, and so on. Despite recent studies, some professionals maintain that sexual abuse only happened in the sixties and seventies. Reflecting community attitudes, some think that sex between professional and patient should be deemed an affair, a private and consensual relationship, or that the sexual involvement was the victim's fault, a product of scheming, greedy machinations, or an outright fabrication. Others acknowledge the wrongdoing but, pointing to those few sensational cases where cruel or bizarre behaviour seems far removed from that of a caring or compassionate health professional, think that there may be a few "bad apples" that bear no relation to the rest of us. Seeing themselves perhaps as benign, compassionate eunuchs, they do not believe that health professionals can be attracted to patients. They ignore professional education about the "slippery slope" which can begin with minor boundary crossings. This attitude carries over into training programs, where medical students and residents still get little instruction about sexual attraction to patients and boundary violations.

The belief that health professionals' bureaucracies and institutions are able to police themselves flies in the face of the recent Ontario study. Health professions, it is believed, are based on an objective and scientific body of knowledge that goes from strength to strength. Training, research and practice within these professions are thought to stand apart from cultural expectations and societal biases such as sexism, racism, and ageism. Similarly, health professionals' inquiry boards are deemed able to be objective and impartial in the handling of patients' complaints. But there is a considerable body of literature demonstrating that the health professions are far from objective and scientific, that they reflect and reinforce cultural biases and stereotypes and tend to maintain the status quo in society. If the members of an inquiry committee are unaware of their biases and victim-blaming tendencies, their objectivity will be clouded and they are much more likely to sympathize with, and believe, their fellow professional whose reputation is on trial and career at stake. This disjunction between what the health professions think they are and the role they may be actually playing leads to considerable confusion and frustration for the professions and to grief, anger and humiliation for the victims.

Intertwined with health professionals' bureaucracies is the legal system. Courts may reverse or endorse findings of boards of inquiry, and lawyers represent accused professionals at inquiries. These lawyers often work for insurance companies, have ample resources to defend the accused, and a sophisticated array of strategies designed to discredit the victim. Lawyers, judges, and juries bring to bear the same kind of biases and assumptions about health professionals and victims that are seen in the health professions and the community. Victims, who appear as witnesses for colleges, are subjected to prolonged waiting periods, lack of communication and support, and harrowing cross-examinations. During this time their healing is put on hold, or their emotional state may worsen, and they become painfully immersed in feelings and memories about the abusive professional.

This array of obstacles is formidable. Clearly there is a paradox. We are asking patients to aid colleges in disciplining their members in the public interest, yet at the same time subjecting them to a process which is intimidating or even terrifying, disempowering, humiliating, lengthy and often completely unrewarding.

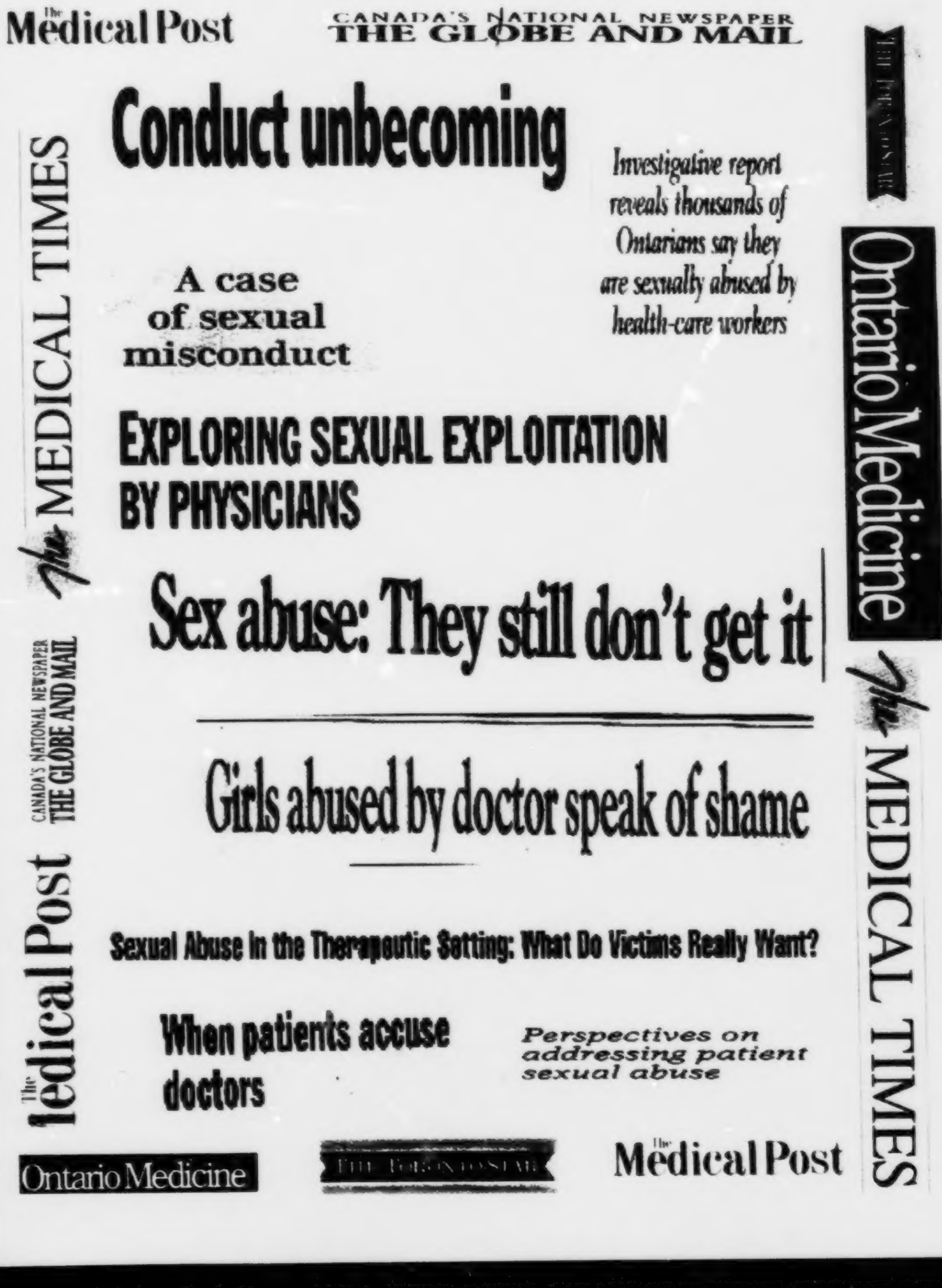
It seems that members of the public are more aware of the paradox than the colleges themselves. There is no easy solution. Changes in public perception and attitudes towards victims need to accompany intensive education of health professionals and creation of a consumer-friendly complaints process.

Hopefully the Special Task Force Report will pave the way for needed changes.

Sue Penfold

CHAPTER 1

Listening to Patients



The Medical Post

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

THE TORONTO STAR

Conduct unbecoming

Investigative report reveals thousands of Ontarians say they are sexually abused by health-care workers

The MEDICAL TIMES

A case of sexual misconduct

Ontario Medicine

EXPLORING SEXUAL EXPLOITATION BY PHYSICIANS

Sex abuse: They still don't get it

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

The MEDICAL TIMES

Girls abused by doctor speak of shame

The ledical Post

Sexual Abuse in the Therapeutic Setting: What Do Victims Really Want?

When patients accuse doctors

Perspectives on addressing patient sexual abuse

Ontario Medicine

THE TORONTO STAR

The Medical Post

CHAPTER ONE

Listening to Patients

"I was put on hold so many times and was switched from person to person so many times that I felt like giving up. The investigators kept switching and they all had different attitudes toward my complaint and me. Eventually I gave up and dropped my complaint."

OUR MANDATE

The study of psychological trauma has a curious history – one of episodic amnesia. Periods of active investigation have alternated with periods of oblivion. Repeatedly in the past century, similar lines of inquiry have been taken up and abruptly abandoned only to be rediscovered...Though the field has in fact an abundant and rich tradition, it has been periodically forgotten and must be periodically reclaimed.[1]

In a letter of January 7, 2000 to her advisory council, Ontario's Minister of Health and Long-Term Care, the Honourable Elizabeth Witmer, asked that we provide her Health Professions Regulatory Advisory Council (HPRAC) with our *Advice and Recommendations* and to provide her with "a summary opinion letter". We sought and welcomed an opportunity to bear witness to what patients had to say about their lived experiences resulting from sexual abuse. We have appreciated the concern and support demonstrated for the work of this Task Force by the Minister, her advisors and Ministry officials as well as the opposition party health critics, Frances Lankin for the New Democratic Party and Lynn McLeod for the Liberal Party.

Those of you who are familiar with the report we prepared for the College of Physicians and Surgeons in 1991 know our preference for including as much direct information from patients as possible. We have had less time, a larger mandate and fewer resources to complete **this** report and no access to college records. Our only access to patient files has been through patients themselves.

Despite these problems, we have tried to create as many access points as possible and to listen carefully to what patients had to say about their experiences with the processes that have had such a huge impact on their lives. When we listened to what patients told us, we felt that time had stood still during the nine years since we submitted our first report. Very little has improved and the kinds of difficulties that patients experience in trying to access self-regulation processes remain much the same.

"I know now of 22 women and I have not done the investigations, but I know that I would never have taken on the college and I would never have survived without the support system and the financial means that I was lucky to have. The college for years succeeded in shutting out many of his other victims. The college kept saying to me that they needed more women. At the trial, it became clear that the college already had other complaints about him before mine, yet it took them 20 months after I gave them his name to proceed"

SUMMARY OF PATIENT REPORTS

Our Task Force received over 60 reports of sexual abuse and some additional reports that did not involve sexual abuse. We were able to follow up with 57 people who complained of having been sexually abused and we met in person with 22 of them. The following is a brief overview of the reports submitted by patients.

- Of the 57 reports of sexual abuse, about 80% came from or on behalf of women (46 reports) and 20% were submitted by men (11 reports).
- Almost 9 % of the reports concerned sexual abuse by female health professionals. Three men and two women reported sexual abuse by female health professionals.
- One young woman who was paralysed and could not speak was represented by her parents. A speech language pathologist also told us that a number of her speech-disabled patients had been sexually exploited by the health professionals on whom they were dependent.
- A number of patients self-identified as members of minority groups, although we did not ask patients to provide this type of information.
- Five patients reported that they were less than 14 years of age when they were abused.

Abuse of patients was reported to have occurred in the following Ontario locations.

- Barrie
- Brantford
- Burlington
- Cambridge
- Chatham
- Fort Erie
- Gloucester
- Kincardine
- Metro Toronto
- Mississauga
- Niagara
- Ottawa
- Penetanguishene
- Shelbourne
- St. Catharines
- Thornhill

- London
- Manila
- Windsor

The following health professions were identified in reports of sexual abuse.

- Psychiatrists
- Physicians
- General practitioners
- Psychotherapists
- Psychologists
- Nurses
- Registered Practical Nurses
- Medical Laboratory Technologists
- Chiropractors
- Physiotherapists
- Dentists
- Massage Therapists.

The accounts that follow are based on information that patients personally provided to the Task Force. Their names and locations, as well as the identity of health professionals, have been changed or omitted except for patients who have been quoted from their reports to the public hearing held by the Task Force. Other identifying features have also been deleted, unless patients specifically requested that they be included.

Some of these patients were prepared to speak at a public hearing. Others were reluctant to meet with us in person and some failed to keep appointments for a private hearing and chose, instead, to telephone or write us. Some patients made extensive inquiries by phone or e-mail but opted not to send us further information. It was not unusual to have three or four telephone contacts with a patient before they were prepared to file a report or speak with the Task Force. Patient requests for confidentiality have been respected.

WHY NOT IDENTIFY HEALTH PROFESSIONALS?

One of the reasons we chose not to identify health professionals, in addition to respecting confidentiality, was to underscore the point that this inquiry is not about castigating individuals, however justified that might be. It is about taking responsibility within a system that is dysfunctional and is not meeting its goals of equity and safety in the public interest. By not 'naming names', we are focusing on the patterns of destructive behaviour that are allowed to operate across health professions and inside institutions.

THE MEDIA

It is important to acknowledge the often constructive role of the media and the genuine concern that some of its members have demonstrated. Without media coverage of this issue as 'news', it would be less well understood and there would be even less accountability in the public interest. Patients and their advocates seldom have the resources to convey their concerns broadly. Nor do they have the resources to stop an assault on their privacy by members of the media. Unfortunately, we have received reports of irresponsible behaviour on the part of some reporters, editors and publishers. These people dishonour their profession by abusing patients' trust. For example, falsely assuring a patient that her comments would be treated as background only and that she would not be identified in the story if she agreed to talk to the reporter, and then using the titillating details of sexual abuse as a 'story about sex'—instead of undertaking an analysis of the damage perpetrated by sexually abusive health professionals or of exposing the myths about sex abuse victims so often perpetrated by defence lawyers.

SURVIVOR REPORTS

We have learned a great deal, as we did in our 1991 investigation and report, from the real experts on the dynamics of sexual abuse—those who have had to learn how to survive the experience. We are honoured by the trust they placed in us and will continue to work as individuals to bring greater fairness to the regulatory college, university, legal system and institutional processes that so often undermine patients who have been sexually abused. We urge you to carefully consider what is being said and to confront the truth about sexual abuse of patients, like 'Andrew', with compassion and courage.

"How is it possible that professionals who are sworn to serve and protect the public, can sexually abuse their patients? That there is a single case of sexual abuse by a health care professional is wrong; that there are thousands is nearly impossible to believe, but that there are few prosecutions and no protection by the colleges is astounding."

When 'Andrew' reported his experience of abuse by a health professional, he used an oxymoron. Health care and sexual abuse **are** incompatible. Patients who are sexually abused represent a limited but very significant percentage of patients in Ontario.

Most health care providers never think of being sexually abusive. Most feel a great deal of pain when they accept the fact that sexual abuse by health professionals occurs more frequently than most people imagine. The facts are that there are sexually abusing providers of health care who have victimised **many** patients, and that many of those abused patients have remained silent.

Acceptance of the fact that intentional harm actually **happens** comes through several avenues. We must experience it ourselves; know and trust someone to whom it has happened; or be convinced by scientifically valid statistics.

In order to accept the frequency of this terrible violation of trust between health professionals and patients, we must stop idealising our health care providers. There is an understandable need to perceive all health care providers as wise, safe and trustworthy even when some have none of these characteristics. We are often more comfortable in the state of denial widely shared in our community at large—that sexual abuse of patients happens somewhere else and that it is not pervasive.

"I had decided not to complain about (him) until I realised that, in my small town alone, there were 13 other victims who had also been his patients."

"When I phoned for information to see where my case was and what was happening, I was brushed off with statements such as, 'We are doing the best we can; we have many cases ahead of yours; we are expediting your case.' This made me really angry and whenever I hear the word 'expedite', I see red."

Patients who report sexual abuse can become pawns in a complicated, expensive process, wherein lawyers and other professionals are paid to operate processes that have not been designed with the needs of patients as a priority.

Many of the recommendations that we have made came directly from the thoughtful and comprehensive reports that were made to us by patients and their advocates. We received written briefs with specific recommendations from over 20% of the patients who contacted us. Our Task Force coordinator, Karen Brown, spent an average of one hour with each patient who made a report by telephone. Members of the Task Force have spent many additional hours on the telephone with patients and their advocates and in personal meetings with many of these individuals.

"When I heard he was abusing other women in my community I became very angry. Prior to that, I had felt so ashamed that I was afraid to talk to anyone. The anger helped me to find out how to complain. When I finally made the call, I was put on hold several times. I had been devastated by the experience and getting up the courage to call required an almost superhuman effort. I desperately needed a sympathetic and supportive response. Eventually all I got was the answering machine. I was so angry that I almost decided to drop the complaint."

During the public and private hearing process that we conducted in preparation for this report, we received volumes of information. In this brief report, we share with you summarised accounts of sexual abuse and trauma that help to demonstrate the entrenched systemic problems addressed by our recommendations.

SHERRIE

Sherrie

'Sherrie' was born in the mid 1960's. She has a congenital malformation of her brain stem with associated hydrocephalus, seizure disorder and severe cerebral palsy. She uses a wheelchair and is unable to make any sounds because her throat is paralysed. Sherrie is chronically ill and completely dependent on nursing staff for bathing, feeding and diapering. At the time of her sexual assault, she was unable to communicate although she was fully alert and oriented.

In February 1997, Sherrie's mother took her to a hospital because she had stopped having menstrual periods. She was told that her 32 year old daughter was pregnant and carrying a healthy 15 week old foetus. The mother recalls that,

> *"because her foetus was so far advanced, we had a terrible struggle accepting that Sherrie had to have an [abortion to save her life]." Six days later and minutes before the therapeutic abortion was scheduled to take place, Sherrie miscarried.*

A Toronto Police Services detective took the foetus to the Centre of Forensic Sciences, where DNA evidence was extracted and preserved. In November 1997, Sherrie's mother received a letter in which a college official said,

> *" This letter is sent to confirm the details of our telephone conversation last week. I advised the panel of the Discipline Committee that your daughter Sherrie, while a patient, was sexually abused by (the health professional)"*

The health professional worked at a hospital and had been responsible for the care and well being of Sherrie. Sherrie's parents told us,

> *"We trusted (the health professional) to give appropriate care for our fragile, vulnerable daughter and he betrayed all of us, especially Sherrie. For the (health professional), Sherrie was a tiny, fragile, helpless young woman who could not run away, could not call for help, and could not tell anyone what he was doing to her. He knew it and took advantage of it behind closed doors when he was supposed to be giving her care."*

The health professional finally admitted, in a plea bargain, that, as Sherrie's health care provider, he had sexual intercourse with her without her 'genuine consent.' The health professional's statement is particularly difficult to comprehend since Sherrie's hips and legs are paralysed and she has little use of her arms and hands. The College revoked his license and he was sentenced by the criminal courts to a prison term of 4 years. The trauma of these events was magnified by the poor treatment the family experienced when trying to help their daughter recover from the trauma.

> *"We might have coped with the rape and pregnancy and eventually put it behind us, but what was unbearable throughout was the way in which the (administration) and the (supervisors) treated Sherrie. Our only concern was that she receive therapy and good, compassionate care because she was so sick and traumatized. Neither of these happened. She was severely depressed, agitated, stopped eating, and tried to kill herself on numerous occasions by banging her head against the wall—knowing that it could destabilize the shunt implanted in her skull."*

Concerned health professionals, who were working at the hospital during this period, told the family about disparaging, sexual comments made, in Sherrie's presence while she was in great distress, by supervisory staff at the hospital.

The family's distress was compounded when they learned that the health professional convicted of preying on their daughter had previous criminal convictions for sexual offences. This meant that the college, as the licensing body of this professional, and the hospital as the caretaker of their disabled daughter, had clearly failed to put in place adequate procedures to protect patients from sex offenders.

This family's experience is not unique. We heard reports from several presenters that stressed the low standard of care they experienced in Ontario health care institutions, particularly in situations where patients were incapacitated and physically or emotionally fragile.

To be consistent with the philosophy of zero tolerance, our recommendation regarding institutional employer responsibilities and database utilisation as a means of protecting the public is based on reports such as these and our direct experiences with a number of Ontario institutions.

SALLY

Sally

"I reported to the Special Task Force about two complaints that I have made to the college since 1992. The complaints were regarding sexual abuse by two different members.

I made the first complaint in 1992 against a member who had sexually abused me when I was a teenager under his care. Five other women also filed complaints against him for sexual abuse. All of the complainants were between 16 and 19 years ago when they first came into contact with this man. We all approached the college individually and at different times.

In 1996, the Discipline Committee of the college heard evidence of the complainants, two expert witnesses and the similar fact witness without any arguments from the defence as they had withdrawn at the beginning of the hearing. The committee found striking similarities in all the evidence and that "the proof was clear, convincing and based on cogent evidence." The committee furthermore found that the member did not meet the standard of practice then or now, and that 'comments of a sexual nature serve no therapeutic purpose and can be harmful to a patient'. The committee then made the unanimous decision that he was guilty of professional misconduct and incompetence. The committee ordered his license revoked. The system seemed to work.

In 1992, I filed a second complaint to the college. This complaint has been dealt with in a completely different manner than the one described above. The process has been extremely slow and seriously flawed.

First, no investigation was ever made into my allegations and, in 1995, the college advised the member that the case had been closed. I was then forced to hire a law firm to represent me and go to the review board for intervention on my behalf into the status of my complaint.

Second, the manner in which the investigation that took place—even after I had appealed and the college had been advised in 1998, that the file (which) should not have been closed without an investigation and without my consent—was unethical, unprofessional, insensitive and insulting. For example, I was contacted by and met two female representatives of the college to discuss the nature of my complaint. They met me in a hotel room and tried to get me to back down.

One of the women actually said to me that I couldn't possibly have been abused by this doctor because someone would have seen it. I see *young people on the street. I was young once with lots of promise and the hope of youth. That was taken from me. These women were re-victimising me.*

Third, I was told that 'I was the only complainant and would never get anywhere with the complaint'. They alleged that I was being abusive because I was complaining about the complaints procedure and the length of time it was taking to deal with my complaint.

As well as the legal arguments about problems with the investigation itself, I have grave concerns about the people the college hires for the investigative team. I think the screening procedures for hiring should be extremely tight.

I felt like I was dealing with a bunch of public school bullies rather than a professional investigative team from the college. I can honestly say that the majority of the individuals I contacted in regard to this complaint were downright ignorant and cruel.

There is a serious lack of motivation on the part of the College to discipline its members for unethical conduct. The length of time it has taken for my second complaint to be processed and the challenges and obstacles I have faced in getting the complaint through the system, have led me to believe that self-governing disciplinary bodies do not work."

ANDREW

In the early 1970's, 'Andrew' was a promising young university student. However, while seeking routine health care treatment, he was sexually assaulted. He told us how his life was forever changed.

Requiring care for a simple oral lesion, Andrew attended a university clinic, where the health practitioner asked him to remove all his clothing and to lie on the examining table. Once he was in this vulnerable position, Andrew was fondled by the health professional. At that moment, he was silenced by the overwhelming power imbalance, but soon afterward, he contacted the college and sought help. It took over two weeks for someone to return his calls, then his concerns were denied, and he felt left to his own avails.

The difficulty that many patients have in reporting abuse is often compounded by a victim's personal and individual circumstances. After his initial attempt to get help from the college, Andrew did not speak of his abusive experience. He told us that the issue of being a male survivor has been especially hard and that it took him many years to tell his wife what had happened. He said that his anguish over the abuse was so strong that, when he and his wife were expecting a baby, he prayed that their child would not be a boy. Even so, Andrew's hope in telling his story now—so many years after the abuse occurred—is that he will be able to send out a message to other males that coming forward can be a positive step.

Andrew is himself a health professional, involved with college processes. He made the following suggestions for improving how colleges deal with the abuse of patients.

- *The college should not be a part of the process of investigation and reporting of sexual abuse by health care providers.*
- *The Ministry of Health and Long-Term Care should set up an independent body to handle complaints.*
- *A database that includes information about how to contact people who could help victims of sexual abuse should be created.*
- *All licensing bodies should offer crisis counselling for members who need help dealing with inappropriate feelings and urges toward their patients.*

GILBERT

In the late 1960s "Gilbert"—an effervescent 14-year-old aboriginal boy, was tragically injured in a fire, receiving burns to 78% of his body. After his long hospitalisation, Gilbert began to have difficulty coping with the emotional and psychological effects of his accident.

Gilbert

"Upon my release from medical care, the reality of the trauma's aftermath quickly came to light. I was angry, lashing out frustration, and uncontrollable. As a result, I found myself in the juvenile court system for delinquent behaviour."

After much involvement with the criminal legal system, Gilbert was again hospitalised. While in care, and during the process of being made a ward of the court, a female patient began to sexually abuse Gilbert, who was then 15 years old.

"Disclosure of sexual abuse by a female on a young adolescent male is most often scorned or laughed at. I learned quickly to keep it to myself."

What made the situation even more devastating was that, during the abuse, a male health care provider and other female patients would stand by as voyeurs, watching Gilbert being abused.

"It was deeply humiliating and dehumanising. I threatened to report her to staff in desperation. She once again laughed at me and told me to take a look toward the audience and see who else was present. She pointed out a male staff member from the adult program who was just around the corner. I saw the same staff member appear again and again during these occurrences."

Those who stood alongside the perpetrator added to the victimisation of this young adolescent. They never offered assistance, never interceded on his behalf, and never considered that—without their participation—Gilbert's abuser might never have been able to inflict the level of trauma that she did.

"At no time did this staff member intervene to stop what was going on. No charges were brought forward. I was completely alone and unsafe."

The haunting trauma of Gilbert's abuse remains with him today.

"I learned that authority figures are untrustworthy. This has had a devastating effect on me since. I have sought treatment and counselling on a

number of occasions for alcohol, drug abuse and post-traumatic stress with limited effectiveness.

Most frightening for me was when I read that people who have been violated in this way will most often be re-victimised, or worse, become a predator. So, when I had children of my own, I experienced paralysing fear around allowing my children to get too close physically with me. I absolutely did not allow my children to climb into bed with their mother and I. I was utterly petrified to change diapers, give baths or the like. My ex-wife often complained about my distant behaviour while we were still married. I could not explain it to her. I realise now how much I lost as a parent and how much nurturing my children were denied as a result of this.

I carried doubt about my ability as a man to protect myself or my family against harm. My ability to enjoy sexual intimacy in my relationship was affected as I would frequently experience flashbacks during sexual activity and would have to stop. Lasting intimate relationships were unstable as a result of this, compounded by my distrust of women and my use of alcohol for coping.

Most of all, I left the institution with a belief that I have carried with me ever since. I am alone in this world. There is only myself to depend on, and with the doubts in myself and the fear I had, I have sought out less than healthy coping styles to get by.

I have suffered many losses in my life, beginning with the fire. I came into this world with all the assets life has to offer. The fire took away many of these. I was sent to that institution in order to get help to cope with the trauma and the losses. Instead, I suffered further trauma and loss, fostered by the silent voyeurs on staff. I received no help at all."

NORA

Following more than two years of care—and after slowly eroding "Nora's" personal, physical and psychological boundaries and grooming her for sexual exploitation—her therapist initiated a sexual relationship. Nora was in a state of deep transference. She was convinced that she was in love and was important and special to him. At that time, Nora told herself that she 'willingly' consented to the 'relationship' and was reassured when he said that he 'loved' her too.

Nora

"The college could have made a very significant difference in my case. I could not believe anybody but him. That belief in him permeated my soul, but if the college had intervened sooner (and) if the registrar had acknowledged that there were other complaints, I believe that the authority of the college would have made the difference. When you are mesmerised by power, it takes an external force to shift the belief in the abuser. Instead, when I asked the registrar if there were other complaints about him, all he said was, 'Well, do you know if there are any other people?'

When I heard the expert witness describe how he turned me into a little girl, I flashed on how he kept trying to get me to perform oral sex on *him in his office and I could only nod my head 'no' back and forth, back and forth, like a little girl. Listening to the expert, I realised then that he planned all along to be able to abuse the little girl in me. Even now, years later, I wake up in a sweat remembering. I feel raped. When he had sex with me, he was raping me. He knew what he was doing, but he didn't care.*

It never leaves me. Never a day goes by that I think about it, but now I see it for what it was. I have never felt such deep, deep pain to the core of my being."

An expert who assessed Nora's situation explained how "consent" could not have been given. Chapter 5 of this report contains more information on why the power of transference necessitates sexual contact guidelines. *"(Nora) could not have made a free choice to consent in the sexual relationship with (her therapist). She was in a sexual relationship with a man who had power over her psychological state of mind and her treatment process. He had initiated erotic contact after a process of grooming her for exploitation and slowly eroding her personal, physical and psychological boundaries and implying that she was special to him and that he 'loved her although he was not in love with her."*

SECONDARY VICTIMS

Sexual abuse also produces trauma in people who are not directly involved. Dr. Gary Schoener,[2] a widely recognised expert on sexual abuse of patients, uses the term 'associate victims' while Dr. Harvey Armstrong, our Task Force colleague, who is frequently called as an expert witness, notes that, *"Secondary or vicarious victimisation occurs when a second person, on learning of the extent and severity of the trauma of a person they care about and are involved with, becomes traumatised and develops post traumatic symptoms."*[2]

The following three statements from Nora's husband 'James', her close friend, and her boss, illustrate this phenomenon.

Nora's Husband, James

"It is only recently that I understand that I am a victim of this abuse. The day I met the task force, it sent shivers through me to have to admit that to myself. That day, I felt for the first time that I had a voice. Because there was a proceeding, I had to contain my anger and keep quiet. I was silenced by the college process.

The college process affects the whole family, not just the victim. There are many victims within a family unit. I felt impotent because I could not protect my wife through the process. I had no power to act—to fulfil my role as her husband. It was all done through another party, like a puppeteer.

My wife should have been treated as a full party. As the victim, my wife deserved to be a full participant in the process, not just used as a witness.

It happened to her!

When they circle the wagons in the college process, the only player in the circle is the professional. Compared to the civil court proceeding, in *the college process, we couldn't get clear information about the procedural rules. We found out, the hard way, that we could not rely on the word of the college, even on the timelines in the legislation.*

They used smoke and mirrors to go through the process, even after the professional admitted he'd had sex, but they never used their power to suspend his license. They did nothing to stop him quickly. He should have been considered incompetent and the college should have removed the media to protect others."

The Task Force received excellent documentation from Nora. It was apparent that Nora had a support system much stronger than many of the other patients who reported to us. The following statements to the Task Force from Nora's friend are a demonstration of the advocacy required to ameliorate the impact of the processes in operation once Nora spoke out.

Nora's Best Friend

"I was afraid that my friend wouldn't get through this process alive and I spent countless hours trying to support her and assist her through the process. I cried many times, wondering if my friend would be alive the next day. I spent hours tracking down professionals who were concerned enough to offer their expertise and/or were sufficiently influential to know the best people to go to for help. Police constables said there was consent when even I, who had no training or expertise in these matters, knew better.

I believe that the college used its legislative mandate and policies to provide the illusion of working in the public's interest and of providing much needed support and assistance to victims. The college repeatedly missed legislative and internal policy timelines as well as reneging on other commitments made to the victim. It was apparent to me, first hand, that the college, and specifically the registrar, had little concern for the victim and, in fact, their actions further eroded (her) self worth as yet another professional downplayed her concerns and instead acted to protect her abuser.

I personally experienced rudeness and indifference to my inquiries when promises were not met and deadlines were missed. What I had expected, as Jane Q. Public, was for the college to provide a lifeline to anyone who finally summed up the courage to call and report abuse by a therapist. What my experience in helping a friend leaves me to conclude is that they are acting to protect their members and their reputation."

Nora's Boss (excerpt from his letter to the college)

"(Nora) worked for me full time in the past and, as I said in my response to your (the college's) questions a year ago, she did excellent work and had an amazing capacity for detail. I need her back as a full time employee. I cannot, in good conscience, continue to employ her on a full time basis until such time as she has some form of closure and can concentrate on her work.

At this time, since she alone appears to have the burden of bringing (him) to some form of justice. She must spend her own precious hours and dollars 'encouraging' people like you to do what you were supposed to do professionally and efficiently in the first place. You must be accountable for any *new victims of this predator, having been advised of his identity and conduct and having the mandate and responsibility to the public for protection against such activity.*

At a minimum, I expected you to suspend his license. I get the impression you don't want to know. I get the impression maybe you sense the magnitude of this problem and you know it's going to look bad that this man practices only by your authority."

MORE SURVIVOR REPORTS

NIKKI

"It's taken me ten years and megabucks in therapy to reach the point of calling the college. After I met with the task force, I decided that I would call. I had told the task force that, if I decided to call, I would let them know how I was treated."

In July 2000, "Nikki" made a telephone call to Marilou McPhedran, Chair of the Task Force. The following excerpts are from that conversation.

Nikki:

"I called the college. They returned the call the same day. I talked to her for more than half an hour. I was not rushed. She was prepared to answer every question until I ended the call because all my questions were answered.

She told me that she wanted me to be completely informed about all the 'difficulties', but she balanced her cautionary remarks with encouraging remarks. I didn't feel that she was trying to impede me. She wanted me to make an informed choice. She told me, 'our job is to prosecute the member. We are deeply concerned about these kinds of complaints.' She wanted me to know that it might look like they were on the member's side during the process.

She told me that this kind of case takes a long time. She didn't offer to send me any information about the process, but I never asked. She explained that first it goes to Complaints. That would take three months because the committee meets every eight weeks and so it could be a year before it goes to Discipline."

Marilou:

"Did she tell you that your complaint might get turned down?"

Nikki:

"No mention that the Committee might turn my complaint away, although she did say that 'if it was determined to be sex abuse, it would go straight to a hearing.' She told me that whatever the standards of practice were (at the time of the abuse over ten years ago) would be taken into consideration. She didn't offer to send the standards to me.

I didn't ask if other complaints had been received, but she did put me on hold to check to make sure that he was licensed with that college. There was no change in her tone when she came back to the phone."

Marilou:

"What else did she tell you about the college process?"

Nikki:

"She explained that I have to give consent for him to release his file on me and I get a copy of it. When she found out it was sexual, she said it would automatically go to discipline. She explained that I did not need a lawyer (but that) the member has a lawyer. She told me clearly that the college couldn't provide counselling to me through the process. She told me again that it was long and difficult."

I asked about therapy funding and she said the member would need to be found guilty (and) then I'd have to apply and I'd get whatever amount they decided to give. She said that it was not compensation. It must have gone to discipline to get the money and that if he was not found guilty, then there would be no money for my therapy."

Marilou:

"Any mention of mandatory revocation of license if found guilty?"

Nikki:

"No mention of that."

Marilou:

"Do you think you'll file your complaint with the college?"

Nikki:

"Here's how I felt. She was being clear and fair to me. I did not feel duped. She told me that people report, (and) and then they start the process. I did feel sobered up by it all, really wondering how for me would this be a good idea. It would take up so much of my energy and concentration and is that really in my own best interests?

My original motivation was to get some support for my own process because it has been so expensive and to stop him abusing, if he still is. I wondered if it would be worth it because I'd be applying for support.

I checked how I felt about cross-examination and the lawyers trying to get me, but I felt I could do that because I'm much stronger now. I still have major questions about whether this is worth it. I'm absolutely clear that I was not strong enough 5 or 10 years ago. It has taken me this long. Right now, I don't think I'll do it, but what do you think?"

BRENDA

Brenda, at the Public Hearing:

"This past year has been a nightmare. I never would have ever thought that I would be in it. I am a victim of sexual assault by (a health care provider). And this man, up until one week ago, was practising and there is no check or balance put in place from the (college).

Some of the problems I encountered along the journey began when I first contacted the college registrar. In my initial contact with the registrar, I advised her that I had been sexually assaulted by a local health care provider and that I wanted this man stopped from hurting other women.

However, I did not want to have police involvement. I made this very clear.

The registrar seemed sympathetic at first and I thought this was the appropriate manner to deal with the situation. I informed her, in vivid detail, of the assault surrounding my complaint. I told her, by written letter, that I would write out the details and send them to her as soon as she gave me, in writing, her word that she would not contact the doctor who assaulted me until I was ready to deal with it. I wrote this letter out and gave it to my family doctor... I had this letter written out and I had given it to my doctor and it was sitting there and it's still sitting there to this day in my doctor's office in my file, waiting for a response from (the registrar).

At this point, my family doctor sent a letter to the registrar telling her of three patients she knew who were sexually assaulted by the same health care provider. My family doctor has yet to receive a response from the college about her letter.

(As) a direct result of the College not even having the decency to respond to either my doctor or my personal complaints, I was left with the only option to subject myself to a police investigation. I had exhausted all other less traumatic avenues in my efforts to prevent [him] from continuing his criminal behaviour. Reluctantly, I reported the matter to the police. I found it extremely traumatic and still, to this day, suffer emotionally as everything hangs in the balance.

I also filed a written complaint with the college. First, I was interviewed by a college investigator. Since then, I have found out that she has no formal training in investigation. She is actually a registered nurse.

Not only that, but the statement I gave to the investigator did not even sound like my statement. There were other victims, other things that were interjected into my statement.

I know of at least one other victim after I informed the college. This is on record at the courthouse. This person need not have been a victim if the college had followed regulations. Of the 14 victims, none of us would have been violated by this man if the college had fulfilled their obligation six years ago when they were contacted.

I did not necessarily expect the college to rescind (the health professional's) license permanently at this time, but I did naively believe that they would create some temporary restraints that would ensure the public safety from the man they have licensed to practise. It was the courts, and only the courts, that placed a restriction on (him) to have a third party in the room when he was treating a woman.

The courts, which have no affiliation with the college, felt the need not to allow this man with any woman patients, as well as forbidding him to have contact with any of the victims he has been charged with sexually assaulting. This shows that the college has either the inability or the unwillingness to ensure that all its members are honouring their oath and obeying the laws of the country. In my opinion, the college is merely a public relations organisation, operating solely under the desire to protect the public's perception of its members.

If a serious matter, such as the one I've gone through, goes unsanctioned by the college, it is obvious that anything of a lesser complaint wouldn't be challenged either. And it challenges me to understand how the college can simply sit on their ... and that this person continues to hold the same privileges as the rest of the (members) that are true to their desire to assist patients.

The College's complaints and discipline process seems not to act until the college is forced, by law, thus leaving the victim who brings forth their complaint left hanging with nowhere to go. (The fact that the colleges) impose no sanctions is ridiculous, to say the least. I have seen other colleges faced with lesser offences suspend their members pending the outcome. Police officers are often suspended for this kind of behaviour. Why not health-care providers? The public needs to be informed about where to file a complaint about sexual misconduct of a sexual nature by a regulated health professional.

In order to eliminate the prevalence of sexual abuse of patients by health care professionals, the obvious solution is for the college to take a hard line against any of their members committing sexual assault and to deal with that member very publicly and quickly so that the general message is sent out that this conduct will not be condoned in any shape or form.

I'm just so frustrated. The fact that I would have to drive by this clinic and see that he is working. What an insult. What a slap across the face. And then you hear lots of innuendos too. Yes, you're not supposed to listen to this stuff, but it hurts. I'm the victim. He is being treated like he is God and he is allowed to do whatever he wants and get away with it and hold his head high.

And when I contacted the registrar, I asked her specifically, 'Are there any findings against him? Anything? She said, 'No. There's nothing. I've looked on the computers, there's nothing.' It was through other means that I found out that he had been complained to and when (she) found out that I knew of this, she got very hostile in conversation with me. Criticizing me for knowing and how did you find out? She was angry. She wanted to know where I found that out. Like that was none of my business."

Brenda's Husband, Rod, at the Public Hearing:

"I have been a policeman for 25 years and continue to be one. For eight of the years, I specialised in investigating sexual assaults. Because of the difficulty in dealing with such cases, each of us that investigate sexual assaults (across the country) is forced to undergo extensive training. Police receive training in cognitive interviewing skills. Yet, the person [investigator for the college] who interviewed Brenda in the [investigator's own] hotel room had no training, no video, no recording. This ridiculous interview, done (without video or audiotape) is just creating a landmine. It is basically creating a wide open door for this person to fight his case later in court.

All police officers are taught that you take a pure version statement. You don't put your own words into it. It is verbatim. And for someone to come in and paraphrase when she is taking notes, that alone is intimidating as a victim of sexual abuse, to take notes when someone is describing the most intimate details of violation. That's why audio and video recording is one of the pri-

mary reasons it's done. It isn't to validate the interview and show the policeman did his job properly or didn't, it is to not try to re-traumatise the victim.

The only sanction placed on this man was by the courts—controlling his behaviour with other patients. The college has yet to do a single thing. He's allowed to resign. If that isn't a PR move....

When a complaint comes from a member of the same college, it must have been the hardest thing that member has to do. To complain about a fellow college member in a small community. He knows this man personally.

Mandatory revocation of an abuser's license is a must in order to instil any confidence in the public. These are the procedures already in place, but it seems there is no standardisation that happens between the colleges. From our experience, we've gone into great detail and we've been pushed right on this right to the hills.

At the date that the information is officially sworn in court, he is officially charged with the criminal offences, yet there are no sanctions from the college to protect the public from this man. Since the college has interviewed the victims, not a single thing has been done. It seems illogical that the college wouldn't act on upon the charges being officially laid and have an interim sanction in place pending the outcome. This is not one isolated incident. At the time, there were at least nine other victims.

It's now a matter of law whether this person is going to be found guilty or not. But there's reasonable grounds to believe, as far as the college goes, that something has to be done, first to protect the public and the second, to protect the remaining members of the profession who are truly doing a decent job."

Three months after giving her report to us, Brenda contacted the Task Force to raise further concerns about how the college and the college prosecutor treated her and other victims.

Brenda

"His other victims and I were put through the criminal process; he finally came before the college where he admitted guilt in all 14 cases. Along with other victims, I was at the college hearing when they revoked his licence for five years. What should have been a feeling of relief that day of the college hearing was tainted, for me and for other victims, by the callous way that the college's lawyer treated us.

This whole process continues to be like a nightmare – weird and hard to predict. It's been a real eye opener for me to see how these people being paid good money to process our cases treat victims - they act like they're doing us a big favour, they take months to respond, months to proceed on very serious charges and months to reimburse our expenses.

If this hadn't happened to me, I might not have believed it - after the college hearing, I started talking to the college's lawyer, who had interviewed me and other victims, and I told him about how disappointed I was in the college's actions, as well as in not being allowed to be present while the discipline board spoke to [the member]. One of the other victims was with me and *we could tell that he was getting annoyed as I spoke. Well, instead of acknowledging our concerns, the college's lawyer snapped at me and said 'Too bad, get over it' then turned his back on us and walked away."*

THE NEED FOR A PATIENT'S BILL OF RIGHTS IN ONTARIO

We heard from a number of patients' advocates at the public hearing. Janet's psychotherapist accompanied her client to share their expertise based on direct, recent experience with a college disciplinary hearing . Both Janet's psychotherapist and Janet emphasised the lack of information available from the college and made recommendations which the Task Force found to be helpful.

Janet's Psychotherapist,

"I didn't know the process that it was going to go through, the steps that are in place and what are the rights of my client so that I can act as an advocate for her, to help her to work for her rights. Nothing was given to Janet and nothing was given to me. A lot of verbal things were conveyed to her by very many different professionals within the college. You can understand what that would be like when they are giving that message at different points in time by different people, and the importance of consistency was not maintained. So, what happened, I don't want to speak for Janet, but certainly what I was feeling as her support person, was a lot of different messages and lack of clarity. So, I think right from the out-start when there is a complaint being made, there should be something in writing that clearly outlines the rights, the obligations, the privileges of the complainant going forward. Not only for the complainant, certainly the one that is also the doctor, maybe he does get something in writing, but from the end going back to what I was saying about the importance of empowerment, there needs to be a clarity about what that process is. The legal process is very confusing for anyone, I think, even in the best of circumstances. But we are not protecting the public if we are not letting the public know what their rights are."

Reports from patients and advocates, such as those brought to the Task Force, reinforce our recommendation that a strong Patient's Bill of Rights must be a priority for Ontario. To be effective in the public interest, the legislation governing health professionals and institutions that provide health services to patients, such as the *RHPA* and the *Ontario Hospitals Act*, need to be amended to require all regulated health professionals and all health care institutions to post the Patients' Bill of Rights and up-to- date contact information wherever health professionals are practising.

Patients explained to us how, in the midst of such damaging experience, the confusion as to resources and remedies available to them compounded the damage. The posting of a Patients' Bill of Rights with clear definitions and standards of appropriate behaviour denotes acknowledgement by all concerned (health professionals, health institutions, the government and the public at large) that the sexual abuse will not be tolerated and that perpetrators will be held accountable.

Patients and patient advocates have repeatedly told us that it is time to codify what patients can expect from health professionals and health professionals have told us that they are hampered in their regulatory work by a lack of clarity as to what is expected of them. When we made our report to the College of Physicians and Surgeons nine years ago, we drafted a "Commitment to Patients Statement" that we recommended be made into a poster and placed in physicians' offices and other health facilities (see the appendix of all our 1991 recommendations at the back of this report) to facilitate a quick growth in awareness as a necessary part of implementing the philosophy of zero tolerance.

In our recommendation this time, we specify that a statutory Patients' Bill of Rights needs to be developed through an expedited, supported process that recruits members of the survivor community who have demonstrated expertise in patients' rights and patient's realities. Writing down rights does not make them so, but the naming of rights in a clear, accessible manner will create a stronger platform of shared understanding from which patients, the public, institutions and health professionals can move forward together.

RECOMMENDATIONS - CHAPTER ONE

ENACTING A PATIENTS' BILL OF RIGHTS

RECOMMENDATION 1

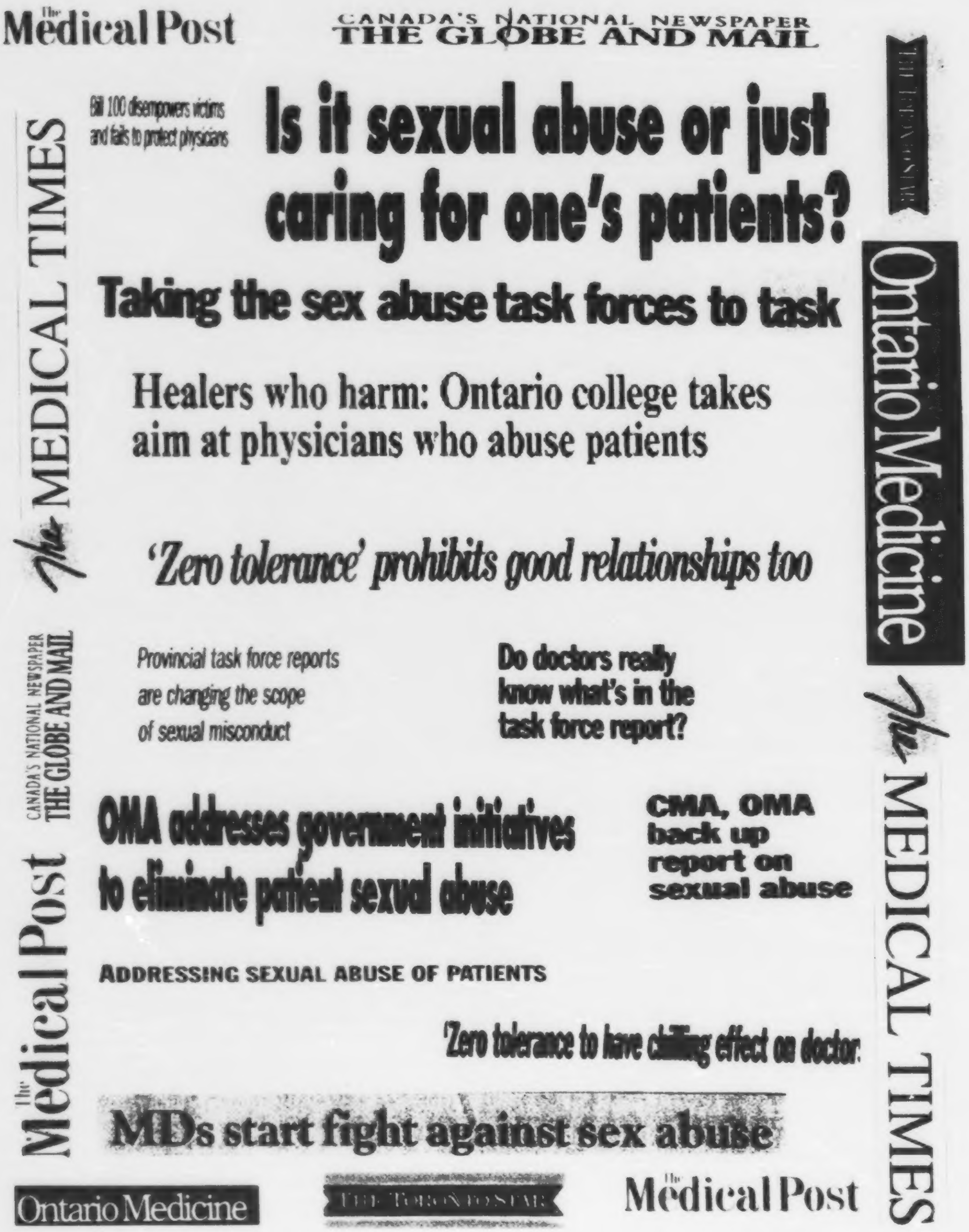
1.0 A Patients' Bill of Rights should immediately be developed by the Ontario Ministry of Health and Long-Term Care, after consultations including patients' advocacy groups and colleges, as an amendment to the *Regulated Health Professions Act* ("*RHPA*") of Ontario, to be made easily available through the Ministry, the Colleges and the Government of Ontario public information systems. The Patients' Bill of Rights must include the definition of sexual abuse in the *RHPA*, a toll free telephone information number, and give clear and accurate information to the public about how to make sexual abuse complaints to the Public Access Centre, which we recommend be established immediately.

Members of the regulated health professions are to be legally obliged to ensure that the Patients' Bill of Rights is posted in every location where their health services are offered, including institutions where they are employed. Removal or failure to post the Patients' Bill of Rights will incur a penalty under the *RHPA*, enforceable by the member's College.

1.1 It is further recommended that the legislation governing health professionals and institutions in Ontario that provide care to patients, such as the *RHPA* and the Ontario Hospitals Act be amended to require all regulated health professionals and all chief executive officers of health care facilities to post the Patients' Bill of Rights and current contact information in high visibility locations wherever health professionals are offering their services.

CHAPTER 2

Through the Lens of Public Safety and Equity



The Medical Post

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

THE TORONTO STAR

THE MEDICAL TIMES

Bill 100 disempowers victims and fails to protect physicians

Is it sexual abuse or just caring for one's patients?

Taking the sex abuse task forces to task

Ontario Medicine

Healers who harm: Ontario college takes aim at physicians who abuse patients

'Zero tolerance' prohibits good relationships too

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

Provincial task force reports are changing the scope of sexual misconduct

Do doctors really know what's in the task force report?

The MEDICAL TIMES

OMA addresses government initiatives to eliminate patient sexual abuse

CMA, OMA back up report on sexual abuse

The Medical Post

ADDRESSING SEXUAL ABUSE OF PATIENTS

'Zero tolerance to have chilling effect on doctor:

MDs start fight against sex abuse

Ontario Medicine

THE TORONTO STAR

The Medical Post

CHAPTER TWO:

Through the Lens of Public Safety and Equity

OUR MANDATE

The following mandate has guided our work and is based on our discussions and correspondence with the Minister of Health and Long-Term Care (the Minister) and her representatives.

To conduct an independent inquiry into the experiences of patients and members of the public on the subject of sexual abuse by regulated health professionals in Ontario in order to provide Advice and Recommendations to the Health Professions Regulatory Advisory Council and the Minister of Health and Long-Term Care as part of the five year review of the *Regulated Health Professions Act*.

BACKGROUND TO THIS REPORT

Ten years ago, our Task Force was commissioned by the College of Physicians and Surgeons of Ontario (CPSO) to prepare an independent report on the sexual abuse of patients. The *Regulated Health Professions Act (RHPA)* was subsequently amended to include Bill 100, which incorporated some of our recommendations and established new processes and standards for responding to and preventing sexual abuse.

Section 3 of the *RHPA* states that individuals are to be treated with sensitivity and respect in their dealings with health professionals, colleges and the Health Professions Appeal and Review Board. But six years after the *RHPA* was amended—and after listening to submissions from some sixty patients and reviewing other cases—we cannot conclude that this goal is being met. This conclusion is supported by a significant amount of new research, including that of Dr. Susan Penfold,[3] who courageously told of her abuse as a patient and wrote the Introduction to this report.

As we said during a roundtable discussion that was convened in cooperation with the Federation of Health Regulatory Colleges earlier this year, "we are not talking about bad people as the cause for systemic dysfunction". We are talking about college processes that have been in place for many years.

Implementation of the *RHPA* has simply not improved to a level that is in the best interest of the Ontario public. Our Task Force sought to determine whether, if the **potential** in the existing *RHPA* was actually realized, the legislative framework is an essentially sound foundation for reforms to the college processes, or whether the *RHPA* is so fundamentally flawed that the public interest cannot be served by perpetuating the self regulation of the health professions.

A CRITICAL QUESTION

As a Task Force, we need to situate our assessment of the extent to which these processes operate in the best interest of the public by noting that, although the review being conducted by The Health Professions Regulatory Advisory Council (HPRAC) is described as "a five year review of the *RHPA*, many of the colleges report that they have not had enough time to decide cases under the *RHPA*. The fact is, even today, many sexual abuse complaints are still being processed under the 'old' Health Disciplines Act ("HDA").

We understand that there are sometimes serious constraints on college resources, and we acknowledge that certain procedural rules under the *RHPA Code* cannot be applied to cases in which the alleged sexual abuse occurred before the *RHPA* was activated in 1994. But we do not accept the argument that the 'old' act has significantly inhibited the capacity of colleges to implement *RHPA* standards to uphold the zero tolerance standard in sexual abuse cases. For example, under both the 'old' and the 'new' legislation, college disciplinary panels and executives have had the discretion to revoke the registration of a member's certificate to practise upon finding the member guilty of sexually abuse.

We believe that college registrars, staff members, governing councils, complaints and discipline committees and college legal counsel—who all share responsibility for patient outcomes—could have chosen to exercise their discretion to apply standards consistent with the *RHPA* more often in sexual abuse cases that have occurred since 1994, even though they were not legally obligated to do so.

Individually and collectively, those who drive the college processes have chosen, in case after case, not to embrace fully what the *RHPA* has to offer Ontario patients or to implement the policy of zero tolerance of sexual abuse. We must therefore ask, "Whose interests are being served?"

ZERO TOLERANCE AS THE STANDARD FOR PROTECTION

BACKGROUND

In 1991, we were able to review the actual case files and decisions of the College of Physicians and Surgeons of Ontario (CPSO). We also reviewed over

300 patient submissions at a time when very little research had been done on this issue. Access to this unfiltered information was crucial in our development of the philosophy of zero tolerance in the recommendation below, adopted by the CPSO Governing Council in May, 1991 and later by the Ontario Hospital Association (OHA).

> *"That the Council of the College of Physicians and Surgeons of Ontario adopt a motion confirming its commitment to the safety of the public by affirming the philosophy of zero tolerance of sexual abuse and, in accordance with that philosophy, develop policies, procedures, practices and education programs that support it." (The Independent Task Force on Sexual Abuse of Patients, 1991)*

Prior to the enactment of the *Regulated Health Professions Act* in 1994, college processes had been evaluated for their impact on patients:

> *"Abuse is trivialised and complainants are subject to scrutiny in a manner that recreates and compounds the original abuse. Complainants are subject to non-founding: there is a limited probability that any disciplinary proceedings will be brought against the health care professional. Complainants are disbelieved and, where believed, the assault is trivialised. Rape myths permeate the disciplinary and judicial response. The complainant is blamed for her failure to extricate herself and her past sexual history is used to discredit her as a complainant. Complaints are characterised as false accusations, women are said to mistake therapy for sexual assault, and vulnerability is exploited by the professional and then used to discredit the complainant.*
>
> *Complainants are psychiatrically discredited and their psychiatric records used against them. Tremendous deference is shown to the health care professional as a caring professional, and psychiatry is used to protect the abuser as profiling him unlikely to abuse."*[4]

More than five years after the *RHPA* was enacted, our Task Force received a detailed letter from a highly experienced patients' advocate, which said:

> *"I have not found consistency across the various Colleges with respect to either their processing of complaints, their investigation and /or their prosecution of sexual abuse allegations. ...victims of sex offences by health professionals are routinely subjected to traumatising, brutally invasive and humiliating lines of questioning which, for the most part, are unopposed."*[5]

A NEW MODEL FOR SELF-REGULATION

In order to gather information we needed to answer the questions put to us, we convened a roundtable with college representatives, with the support of the Federation of Health Regulatory Colleges. The questionaire we sent to the colleges in advance of the roundtable is in Appendix III. During this time, HPRAC was doing separate specialized reviews on the colleges' processes and programs, but the Task Force did not have access to most of this information.

Some colleges gave us the submissions they had made to HPRAC and we were able to obtain others from the HPRAC website.

Widespread concern about lack of resources and duplication was evident in the colleges' submissions we reviewed and this was reinforced during our

May 2000 roundtable discussions with college representatives. We appreciated their assistance and acknowledged that these discussions placed the colleges in a difficult position; since we were asking them for information they had already given to HPRAC, but that HPRAC had concluded it was constrained from making available to the Task Force.

In June, 2000, the Ministry of Health and Long-Term Care wrote to us and asked that we initiate no further contact with any of the colleges, in order to avoid duplication of work already done by HPRAC. (see Appendix I)

Our Recommendation 3 to amend the *RHPA* to create a new central service agency, the "Public Access Centre" (PAC), is in response to information received from patients and their advocates, the colleges and HPRAC itself.

We are convinced that 'leaving things as they are' will not improve the efficacy of self-regulation nor serve the public interest. We believe that if self-regulation is to merit continued authority and credibility, the public's first point of contact in cases of sexual abuse, and continuing service and support to complainants, can no longer be left with 21 separate colleges—some of which have no previous experience in this aspect of self regulation. This belief is reinforced by numerous college submissions to HPRAC that reiterate the concern that implementation of the *RHPA* process is seriously challenging their resources. A centralised, co-ordinated access centre can focus resources on advocacy, public education and a complaints process to catalyse the prevention of sexual abuse of patients. The access centre can work **with** the colleges, on a shared mandate in preparing members of college councils to conduct their peer review and to render decisions based on accurate knowledge of the dynamics of sexual abuse.

WHO COUNTS?

Judith Herman's classic work, *Trauma and Recovery* (first published in 1992), and Dr. Susan Penfold's *Sexual Abuse By Health Care Professionals* (published in 1998), should be mandatory reading for all health care professionals. They convey much wisdom and they concur on the explanation of our responses when humans intentionally harm other humans. They both speak to the widespread denial, by individuals and society, of the incidence and impact of abuse. They both underline that perpetrators of abuse do everything they can to assist in society's denial of the seriousness and prevalence of sexual abuse. This phenomenon includes sexual abuse by health professionals. With her publisher's permission, we have included the full text of Dr. Herman's Afterword, "The Dialectic of Trauma Continues" at the end of this report.

"The knowledge of horrible events periodically intrudes into public awareness, but is rarely retained for long. Denial, repression, and dissociation operate on a social as well as individual level". (Judith Herman, Trauma and Recovery, 1997 at page 2)

Health professionals have understandably challenged us, during the course of our work, about the extent of the sexual abuse problem. We have encountered a persistent belief that reports of sexual abuse have been caused by "just a few bad apples" and that the regulated health professions are doing a good job of self-regulating. We do not agree. However, it is our advice that it is unfair and unrealistic to place the onus for solutions to this problem on the regulatory colleges. Society must share in this responsibility and we conclude that a model of self-regulation that is more co-operative and supportive is the way to do a better job – in the public interest.

Quantifying the extent of sexual abuse by health professionals is useful, but pursuit of 'the numbers' must not be allowed to divert our attention and resources from redressing the damage already done to thousands of Ontarians who live with the debilitating after effects of this exploitation. We know enough about 'the numbers' to know that this is a public health problem that is real, that is deep, and that the numbers are in the hundreds of thousands. We also know enough about the numbers to know that we must take effective remedial and preventive action – now.

STUDIES ON PREVALENCE IN CANADA

EVALUATING THE "NUMBERS"

We reviewed the literature on sexual abuse of patients by physicians.[6] We looked at 13 studies prepared between 1973 and 1997. Twelve of these studies involved sample groups of physicians and dealt with the prevalence of self-reported sexual contact with patients. Two measured rates of sexual abuse by physicians, as reported by patients. One of the 13 studies reported on both types of samples.

Self-reported rates of sexual contact by physicians ranged from 0% (Canadian psychiatric residents, 1991) to 13% (U.S. physicians, 1973). However, there are problems with these data. These surveys were based on self-reports and we know, from other literature, that sexual offenders tend to significantly under-report the number of times they commit sexual abuse. Furthermore, response rates to the surveys, which ranged from 19 to 78 per cent, may not be truly representative of physicians in general. In particular, there is reason to believe that low response rates may tend to underestimate prevalence, because physicians who are abusing may be less likely to respond to such questionnaires.

There is also reason to believe that what physicians have self-reported as sexual abuse may be different and more limited than current CPSO definitions. For example, in a 1994 study of Canadian obstetrician-gynaecologists, Lamont et al[7] found that 10% of their sample reported knowledge of a colleague who was sexually involved with a patient, but 23% reported awareness of sexual involvement that would be viewed as sexual impropriety, transgression, or violation as defined by the CPSO. It should be noted that all of these studies asked respondents whether they had ever had 'sexual contact' (which was defined in a variety of ways).

The first study regarding sexual abuse of women and harassment by Ontario physicians was conducted in 1991 by Dr. Earl Berger and associates for the CPSO and published in the Canada Health Monitor.[8] In this survey of 549 Ontario women, 7% of respondents reported inappropriate watching or sexualised comments by a physician and 2% reported sexual abuse involving physical contact. In total, 8% reported either or both experiences.

The Canada Health Monitor figures are much higher among women with a university education. 12% of these women reported inappropriate watching or comments, 4% reported sexual contact and 15% reported either or both experiences. In Dr. Berger's opinion, the 15% figure is a more reliable estimate of the extent of sexual abuse by physicians.

At the beginning of our term as a task force, we were aware of the only study done, to date, which asked about all health professionals, not just doctors. Conducted at HPRAC's request in 1999 by Pricewaterhouse Coopers (PwC), this study surveyed experiences by Ontario men and women of "inappropriate behaviour/remarks" and/or "sexual touching/contact involving health professionals" from 1994 through 1999. This study was one aspect of the evaluation of health professional regulatory colleges' complaints and discipline processes related to complaints of a sexual nature. HPRAC informed the Task Force that it was not in a position to share the report, but did meet with task force members in April of this year to share key findings from the work done by PwC. As a result of an access to information application, the survey information became available in August.

We were informed by HPRAC, in a communication from the chair in August of this year, that the "study in question found that one per cent of respondents (men and women) had experienced sexual contact/touching by a health professional and two per cent had experienced inappropriate behaviour/remarks from 1994 to 1999 – rates lower than the 1991 study among women alone."

It is our advice to proceed very cautiously in reaching conclusions about prevalence of sexual abuse of patients by the full range of health professionals, based on the HPRAC survey discussed above. While commendable as an attempt to assess incidence of sexual abuse by members of the 23 regulated health professions in Ontario, the HPRAC survey was actually based on a significantly smaller sample (about 640 male and female respondents) than originally planned. In Ontario, there are over 22,000 doctors registered with their college and more than 144,000 Registered Nurses and Registered Practical Nurses registered with the College of Nurses.[9] There are 21 other regulated health professions covered by the *RHPA*. The small sample in the HPRAC survey is by itself a source for cautious interpretation because it, in effect, leaves out many of the regulated health professionals. Furthermore, the comparison that HPRAC is making between its survey and the 1991 Canada Health Monitor survey merits hesitation.

The 1991 Monitor survey found much higher incidence of abused women, but these figures related to their lifetime experience, and not simply to the previous five years. That would be one partial explanation for the difference, and suggests that conditions may be improving.

If, however, we follow Berger's experience[10] with reporting patterns on abuse, we can reasonably assume that the reporting patterns obtained in the PwC survey are the same as those obtained in the Monitor and other surveys. It is our understanding that: (1) the reports of abuse among those with university education, or those 25-44 years of age are about twice as high as the average, and might run in the range of 4%; and (2) this range is representative of the experience of older people as well.

If we accept that 4% as a reasonably conservative estimate of the percentage of Ontario men and women who have experienced sexual abuse in the previous five years, abuse by health professionals takes on considerable significance. There are 10 million people in Ontario. Assuming about 8 million are represented in the recent survey (because children were not included), it is not unreasonable to estimate that well over 200,000 Ontarians—likely more, taking into account under reporting—have experienced sexual abuse at the hands of health professionals during the five years that the *RHPA* has been in force.

In our opinion, these data clearly indicate that sexual abuse by health professionals is a **substantial** problem. The data are of particular concern if we compare the 200,000-plus estimate with the comparatively small number of complaints received by colleges during that period.

The data compel us to say that sexual abuse by health professionals remains an important public safety problem whose importance is magnified when we consider the specific impact and severity of sexual abuse due to breach of trust. We feel strongly that we must no longer deny the seriousness and prevalence of sexual abuse of patients and the inadequacy of our responses.

The “ PAC” - The Regulated Health Professions Public Access Centre

The nature of this kind of sexual abuse works **against** uncovering the truth and eradicating abusers. Society must recognise this in designing or evaluating any system to address it.

We have learned from our previous work that, inherent in the dynamics of sexual abuse by health professionals, are multiple and interacting factors that strongly bias against identifying, assessing and disciplining abusers. These factors include:

- denial by victims, which is part of the typical response to any sexual abuse;
- difficulty with feelings of complicity, whether initiated by the perpetrator or believed by the victim;
- additional shame, self-doubt and sense of loss when the sexual abuse involves a breach of trust;
- systemic factors, such as the belief that professional bodies related to the perpetrator will be inherently favourable to the perpetrator;
- the traumatising effect of investigative procedures; and
- factors inherent to the professional, such as a health professional's own difficulties with denial.

This bias must be recognised in designing or evaluating any system to eradicate sexual abuse by health professionals.

We must explore **all** of the ways this bias creeps into the system and be vigorous and systematic in designing strategies to address it. For example, if we cannot get people to come forward with complaints, we can't find out who is abusing and deal with them appropriately. Every time a patient is turned away by a college telephone response to the initial inquiry, every time a patient gives up and withdraws from the process – the number of complaints may decline but the problem does not.

Making the process more sensitive to complainants is important—not just to be compassionate to survivors—but because it is crucially important in making the system work. We commend the following points from submissions to HPRAC in 1999.

There are many places within the system where dysfunction can occur without it being an obvious barrier to public access. According to the College of Respiratory Therapists, the financial structure that has been established by the Ministry of Health and Long-Term Care—coupled with uneven training— promotes rather than diminishes differences between public and professional members of College councils.

The College of Dental Technologists believes that accountability and efficiency would be materially enhanced if the ministry provided public members of college councils with more and better training about their legislated responsibilities and those of their colleges. The college also thinks a common training program would be considerably more efficient than the current approach. The College of Physiotherapists supports this view and recommends that the Ministry of Health and Long-Term Care educate all regulated and unregulated persons who are required to make mandatory reports pursuant to section 85.5 of the Code.

It is clear from our discussions that, while the staffs of some regulatory bodies possess a good understanding of the dynamics of sexual abuse, they may not fully appreciate the power differentials involved or the degree of damage that can be inflicted upon those who are the victims of sexual abuse. It is also clear from the outrage and pain expressed by complainants that the staff of some colleges— up to and including registrars—may lack the training or the empathy necessary to help sexual abuse survivors cope with what has happened to them and thereby fulfil their own professional obligations.

The Public Access Centre that we recommend establishing would be better positioned to deliver consistent, responsive education and training as a top priority, in co-operation with the colleges. It should be noted that, for more than five years now, the colleges have had the statutory obligation to provide training and education through the establishment of Patient Relations Committees that are required to develop measures for preventing or dealing with sexual abuse including:

a. educational requirements for members;

b. guidelines for the conduct of members with their patients;

c. training for the College's staff; and

d. the provision of information to the public.

Unfortunately, we found that the implementation of this statutory obligation has been inconsistent. In one of the largest colleges, the Patient Relations Committee was fully activated only last year.

A similar statutory obligation is contained in Prince Edward Island's legislation, *An Act to Amend the Medical Act, l997*. Section 38.5 of this act states that the council shall have a continuing program for the purposes of preventing and dealing with sexual abuse including: "*a) obligatory training for all physicians in matters of law, unacceptable behaviour, warning signals, prevention tactics, and; b) publication of guidelines for physician conduct with patients to prevent abuse.*"

It is essential that both professional and public members of college boards and their various committees receive consistent and adequate education and training in these areas, across disciplines. That is why we have recommended that the Regulated Health Professions Public Access Centre (PAC) do this.

How will the PAC deliver timely responses that are in the public interest?

A number of self-regulatory bodies,[11] including the College of Psychologists, the College of Massage Therapists, the College of Occupational Therapists, the College of Medical Radiation Technologists, the College of Physiotherapists, and the College of Dental Technologists say that it is often difficult to comply with the *RHPA*'s 120-day timeline for disposing of complaints. Patients have also raised concerns, during public and private meetings, about the failure of colleges to resolve complaints within 120 days. The following excerpt from a patient's private submission is an example.

> *"The RHPA should make the timeline for disposing the complaint enforceable and it should set a timeline for appeals. Also, most complainants are unaware of their right to a timely disposal of the complaint and about their right to ask the appeal board for intervention if the timeline is not met. In our case, the complaints committee rendered its decision fifteen months after the complaint was filed. We appealed the decision to the board. It took three years and five months for our appeal to be disposed of."*

The following judicial decision, which was handed down in the case of *McIntosh v. the College of Physicians and Surgeons of Ontario*, reinforces the need for timely disposition of complaints.

> *"Section 26 of the RHPA gives the board the explicit power to extend time limits and particularly the obligations, under Section 28(1) of the Code, to dispose of complaints within 120 days. No such power is given to a college registrar. Notwithstanding that the registrar has no statutory power to extend time, and that no application was made to the board, the registrar allowed the complaint to be dealt with over a period of time that exceeds the allowable time more than ten fold. While the legislation does not, as it does in some other types of complaint processes, 'bristle with time requirements', it is clear on reading the legislation that the intention is that complaints be disposed of expeditiously."*[12]

The task force recommends establishing the Regulated Health Professions Public Access Centre (PAC) and an HPRAC Monitoring Team as two crucial mechanisms for redressing the situation. Some of the colleges clearly support more timely dispositions and the value of review processes. For example, the College of Respiratory Therapists has stated that additional mechanisms to promote the ongoing effectiveness of self-regulation, such as continued statutory evaluations by the Health Professions Regulatory Advisory Council, and more clearly defined Ministry of Health and Long-Term Care functions would be useful.

In his recently updated book, Richard Steinecke—a lawyer specialising in this area of administrative law—makes the following statement. *"Most colleges do not normally dispose of complaints in 120 days. There is significant public interest in the discipline committee proceeding with the hearing on a timely basis."*[13]

ANNUAL REPORTS FOR THE PUBLIC RECORD

Much can be gained through this straightforward procedure. We commend Section 38,5 of Prince Edward Island's An Act to Amend the Medical Act, 1997, which is quoted above, as a positive example of existing legislation. "The council shall have a continuing program for the purposes of preventing and dealing with sexual abuse including (e) an annual report to the Minister, for each of the five years following the start of the program, which provides information on the volume and nature of sexual abuse complaints and the consequent investigation and discipline."

RECOMMENDATIONS - CHAPTER TWO

UPHOLDING THE ZERO TOLERANCE STANDARD

RECOMMENDATION 2

2.0 The philosophy of Zero Tolerance of sexual abuse of patients must remain the guiding principle for the development, implementation, and evaluation of all policies and practices designed to stop sexual abuse by health professionals.

The Ministry of Health and Long-Term Care, the Health Professions Regulatory Advisory Council, the Federation of Health Regulatory Colleges of Ontario, individual colleges and health care facilities should follow the action of the College of Physicians and Surgeons of Ontario and the Ontario Hospital Association in formally adopting the philosophy of Zero Tolerance to guide implementation of policies and practices protecting the public through self regulation. Any review of the *Regulated Health Professions Act* should specifically evaluate implementation of this standard for protection of the public.

THE NEW "PUBLIC ACCESS CENTRE"

RECOMMENDATION 3

3.0 The *Regulated Health Professions Act* ("*RHPA*") should be amended to create a central service agency - the Regulated Health Professions Public Access

Centre ("PAC") - which will share some responsibility for processing inquiries and complaints about sexual abuse by regulated health professions with their colleges by providing:

a) the investigation of patients' complaints under the *RHPA* from first contact through to determination by Complaints Committees as to whether the complaint is to proceed to a disciplinary panel under the *RHPA*;

b) in an expeditious manner, the processing of complaints of sexual abuse including where civil/criminal proceedings have also been initiated against the health care professional;

c) information to patients and other members of the public including access to a provincial data base on sexual abuse complaints and cases involving regulated health professionals in Ontario, with linkage to national and international data programs;

d) support and advocacy services for patients who report experiences of sexual abuse by regulated and unregulated health professionals in Ontario, including some funding of patients' advocacy groups and patients' advocates;

e) pre-professional and continuing education and training programs, designed to eliminate sexual abuse of patients, in cooperation with health regulatory colleges, post secondary institutions and advocacy groups;

f) training of members of governing councils of the colleges under the *RHPA* as a prerequisite for eligibility to decide discipline cases on charges of sexual abuse;

g) training of staff of colleges, including legal staff and retained counsel, in the dynamics and impact of sexual abuse of patients to ensure consistent and relevant hiring criteria and performance standards for college personnel dealing with sexual abuse of patients;

ANNUAL REPORTS FOR THE PUBLIC RECORD BY COLLEGES AND HPRAC

RECOMMENDATION 4.0

4.0 The *RHPA* be amended to include the requirement that every college shall make a public annual report to the Minister of Health and Long Term Care of any complaints received, concerning the sexual abuse of patients by members or former members of the college, including a summary of the timeline and description of actions taken by the college in disciplinary procedures.

4.1 The HPRAC Monitoring Team, to be established pursuant to Recommendation 7.0, should design the template for this annual report, in consultation with patients' advocacy groups, the colleges and the Public Access Centre. This annual report should include:

(a) the number of complaints of sexual abuse received during the calendar year;

(b) the date each complaint was received;

(c) a description of the complaint, decisions with respect to the complaint and the date of any decision;

(d) the decision of the Discipline Committee, including any penalty imposed;

(e) the date and outcome of any appeal;

(f) any other complaints related to *RHPA* provisions to stop sexual abuse of patients, such as posting of the Patients' Bill of Rights in every location where members offer health services;

(g) an explanation and description of the time taken and the process followed, including whether the member's identifying information is available to the public, if the complaint did not go to a discipline hearing; and

(h) specific details as to any fines or penalties imposed as prescribed by the Health Professions Procedural Code ("*RHPA* Code").

RECOMMENDATION 5

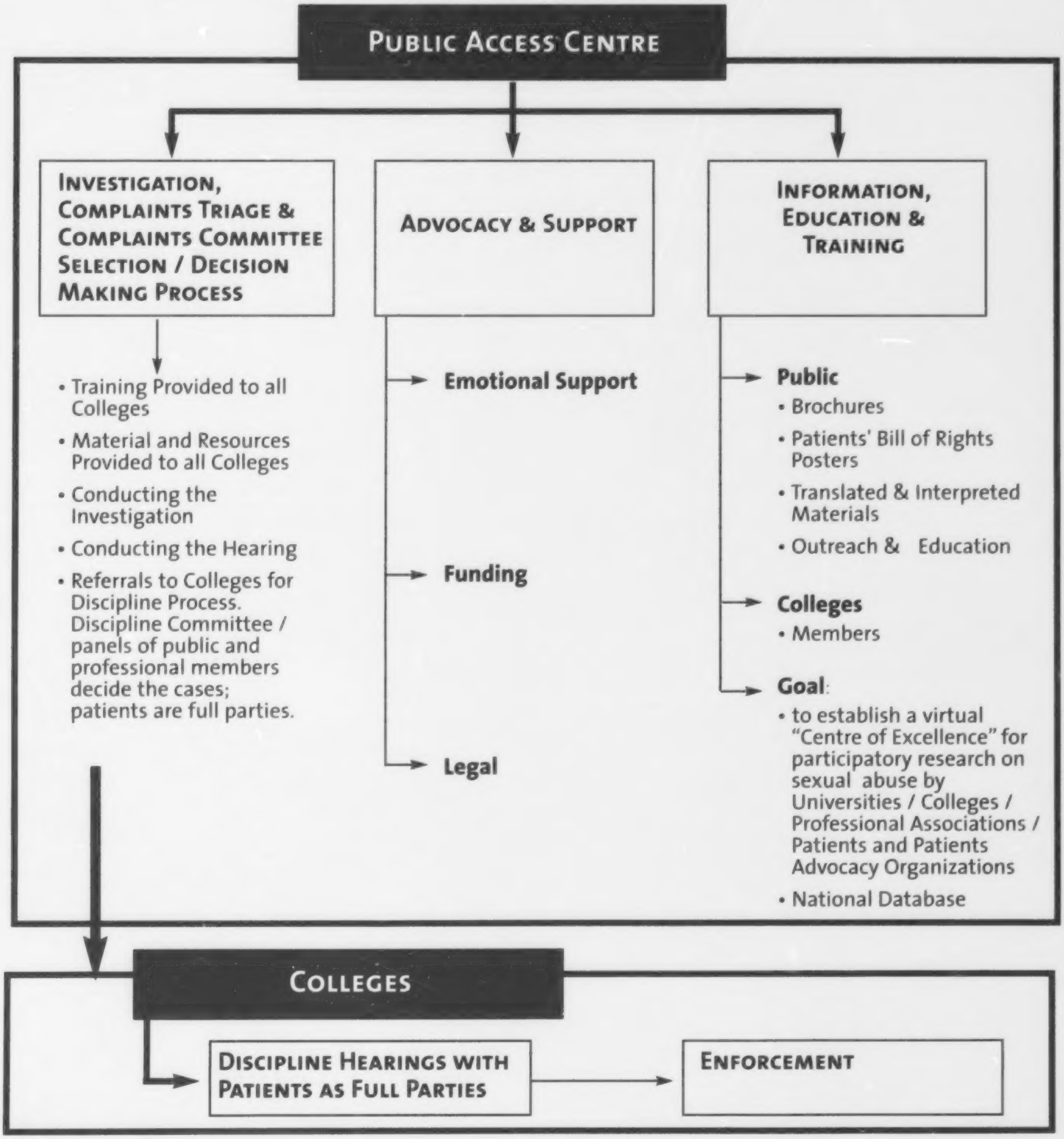
5.0 Following every determination and resolution of a complaint about sexual abuse, every college is to ensure an evaluation form is sent to every patient involved in the process, including a pre-paid return envelope addressed to the HPRAC Monitoring Team.

RECOMMENDATION 6

6.0 The HPRAC Monitoring Team should be required to make an annual report to HPRAC and the Minister for the public record, including a detailed summary of the patient evaluations in the preceding recommendation and suggestions for more effective procedures in the public interest.

THE REGULATED HEALTH PROFESSIONS PUBLIC ACCESS CENTRE - THE "PAC"

This recommendation for a new centralized agency, the "PAC", to be supported by all the Colleges and the Ministry, constitutes the core of our advice for a fundamental change in access to college processes. The PAC should be primarily responsible for facilitating public access, up to and including the management of the complaints process, in cooperation with the colleges, in a consistent, fair manner, regardless of the college involved. In order to achieve this goal, patients must be accorded full party status under the Regulated Health Professions Act and Code. Funding for the PAC will come from the colleges and the Ministry, including proceeds from fines levied in sexual abuse cases.



PUBLIC ACCESS CENTRE

INVESTIGATION, COMPLAINTS TRIAGE & COMPLAINTS COMMITTEE SELECTION / DECISION MAKING PROCESS

- Training Provided to all Colleges
- Material and Resources Provided to all Colleges
- Conducting the Investigation
- Conducting the Hearing
- Referrals to Colleges for Discipline Process. Discipline Committee / panels of public and professional members decide the cases; patients are full parties.

ADVOCACY & SUPPORT

Emotional Support

Funding

Legal

INFORMATION, EDUCATION & TRAINING

Public

- Brochures
- Patients' Bill of Rights Posters
- Translated & Interpreted Materials
- Outreach & Education

Colleges

- Members

Goal:

- to establish a virtual "Centre of Excellence" for participatory research on sexual abuse by Universities / Colleges / Professional Associations / Patients and Patients Advocacy Organizations
- National Database

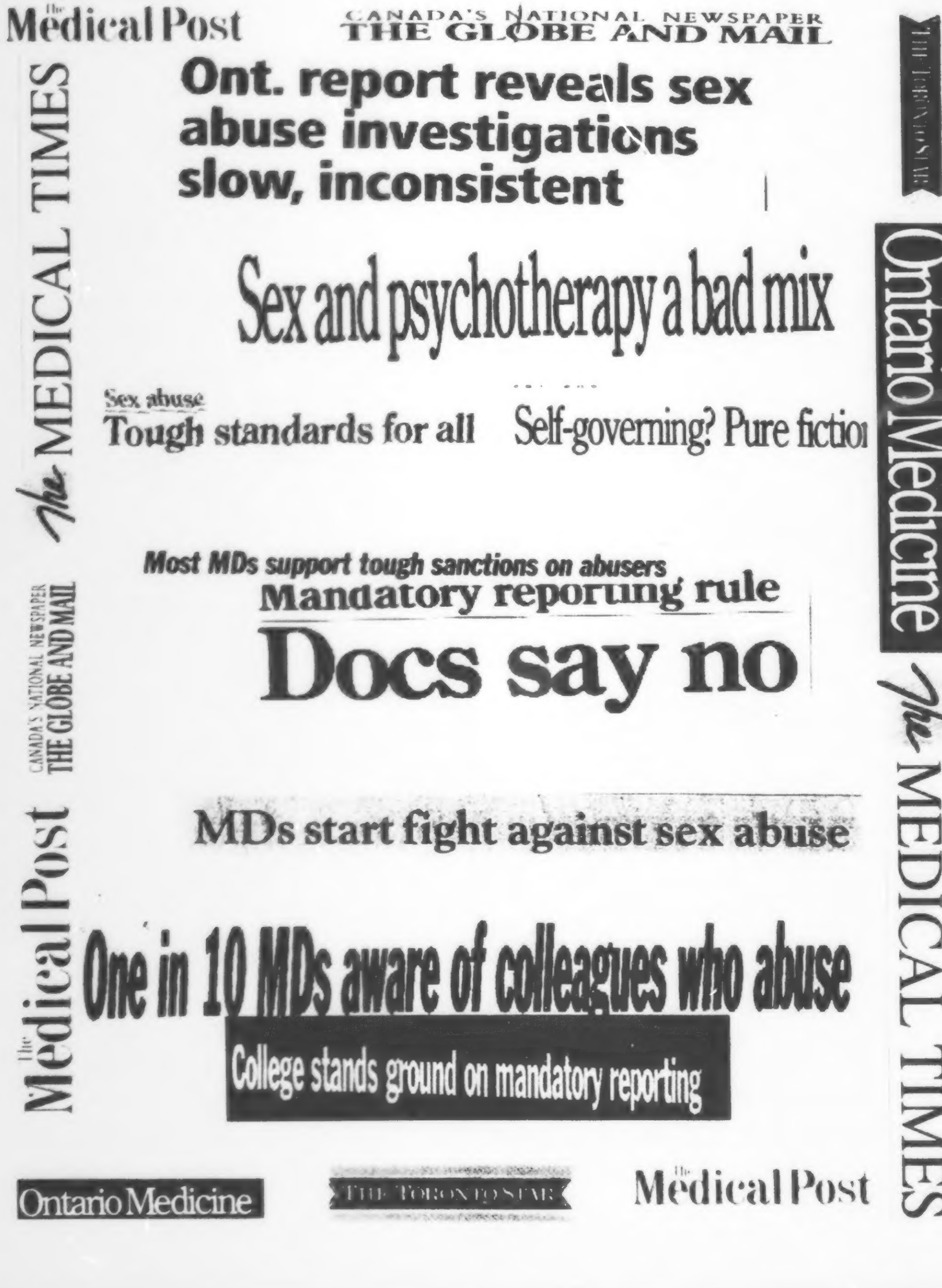
COLLEGES

DISCIPLINE HEARINGS WITH PATIENTS AS FULL PARTIES

ENFORCEMENT

CHAPTER 3

Self-Regulation in the Public Interest



The Medical Post

CANADA'S NATIONAL NEWSPAPER THE GLOBE AND MAIL

THE TORONTO STAR

The MEDICAL TIMES

Ont. report reveals sex abuse investigations slow, inconsistent

Sex and psychotherapy a bad mix

Ontario Medicine

Sex abuse

Tough standards for all

Self-governing? Pure fictio

Most MDs support tough sanctions on abusers

Mandatory reporting rule

Docs say no

CANADA'S NATIONAL NEWSPAPER THE GLOBE AND MAIL

The MEDICAL TIMES

MDs start fight against sex abuse

The Medical Post

One in 10 MDs aware of colleagues who abuse

College stands ground on mandatory reporting

Ontario Medicine

THE TORONTO STAR

The Medical Post

CHAPTER THREE

Self-Regulation in the Public Interest

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD (HPARB)

Some patients told us that the review board was a very helpful countermeasure to delays by colleges, but the majority reported delays and treatment by HPARB that they considered disrespectful and insensitive.

For this reason, we recommend that the PAC and the HPRAC Monitoring Team be joint ventures with clear obligations to the public, including the publication of an annual report. Our task force explicitly advises against any new mechanism that is based solely within the Ministry of Health and Long- Term Care or an agency of the ministry.

We concur with the College of Respiratory Therapists' view that delays in this appeal process are problematic. The college says, at page 12 of its submission to HPRAC:

> *"In some cases, complainants have lost interest and confidence in the outcome of the appeal because of the long waiting time"*

The College of Physicians and Surgeons says, at page 17 of its submission to HPRAC:

> *"The Health Professions Appeal and Review Board is experiencing a large backlog of cases and needs to be appropriately resourced to clear this backlog."*

EVIDENTIARY RULES FOR HEARINGS

In our 1991 report, we cautioned the College of Physicians and Surgeons of Ontario that intake personnel, investigators and members of complaints and discipline committees were de facto applying the criminal law standard of 'beyond a reasonable doubt' in their approach to sexual abuse cases.

Many patients have reported that this attitude remains prevalent. It is our impression that the college processes, which are supposed to be civil proceedings, are more frequently applying the evidentiary rules used in criminal proceedings. While it is true that courts seem inclined to reinforce this tendency, it is our advice to pay close attention to the impact that this change is having on self-regulation in the public interest. We must ask whose interests are being served by criminalising the standards for a civil proceeding.

Decisions made by colleges in processing complaints are affected by what colleges expect to be admissible evidence in hearings. Patients are being turned away because it is anticipated that their evidence will not be sufficient to meet the de facto criminal standard of proof. It is time to draw a clearer line between civil and criminal evidentiary standards and to affirm the civil standards.

In his report to the Attorney General of Ontario on sexual misconduct in Ontario schools, the Honourable Sydney L. Robins[14] commented, as follows on the value of applying the civil standard of proof in admissibility of evidence in administrative law proceedings:

> *"The rules governing admissibility of evidence in administrative hearings are much more relaxed that in criminal proceedings. Section 15 (1) of the Statutory Powers Procedure Act, which applies to proceedings before an Ontario College of Teachers discipline hearing, provides that a tribunal may admit relevant testimony or documents as evidence at a hearing, whether or not given under oath or affirmation or admissible as evidence in a court."* (at page 229)

A contentious issue in college sexual abuse cases is the rule against "hearsay" statements. Hearsay is defined by the Supreme Court of Canada in the case of R v. O'Brien (1977), 38 C.R.N.S. 325 at 327 (S.C.C.) *"It is settled law that evidence of a statement made to a witness by a person who is not himself called as a witness is hearsay and inadmissable when the object of the evidence is to establish the truth of what is contained in the statement."*

At page 231 of the Robins Report, in reference to hearsay evidence, he goes on to say: *"It is appropriate to apply a lower threshold of reliability and necessity, in civil and most particularly, in administrative proceedings.*

Recommendation 18.2 at page 237 of the Robins Report is the formal recommendation made to the Government of Ontario from this carefully considered process. It specifies that *"in administrative proceedings, a lower threshold of necessity and reliability should be applied to the hearsay statements of witnesses, particularly in cases involving alleged sexual misconduct. This accords with the nature of these proceeding and the appropriate balance between competing interests."*

The complaints and discipline processes - as they currently operate and as we envision them in our recommendations – are governed by principles of administrative law. We endorse the recommendation in the Robins Report on hearsay evidence and adopt the more general statement of The Honourable Sidney Robins that the lower civil threshold *"accords with the very broad discretion conferred upon administrative tribunals to admit relevant evidence and the less formalistic approach adopted by such tribunals."* (at page 232)

DISCLOSURE OF PATIENT'S IDENTITY

Mandatory Reports

Fear of disclosure of their identity is a huge deterrent to many patients—not just at the initial point where the patient trusts a health professional enough to tell them the truth about being sexually abused, but throughout the process.

In reviewing notes from the private hearings and the public hearing transcript, every patient who addressed this question (see May 24, 2000 public hearing transcript) affirmed the need to choose when his or her name was released to a college. We know from reports from patients who have gone through a college process, that the stress, frustration and damage that many describe as a result of the college processes must not be underestimated. The low level of trust in self-regulation must not be exacerbated by removing one of the few aspects of the complaints and discipline process in which patients have some degree of autonomy. We urge you to read the introductory sections of this report and the Afterword for a more complete discussion of a patient's need for confidentiality, until he or she is ready to take the risk of being identified to a college or, using our mode, the Public Access Centre staff and the colleges.

Hearings and Publications

The issue of publication bans to protect the identity of patients involved in disciplinary hearings needs to be addressed. It is not enough for the name of the person to be excised in media or college publications. It is important that facts or characteristics that can identify the complainant also be deleted. This is a particular problem in small towns and rural areas.

We advise HPRAC to clarify what colleges are telling their members and members of other colleges about their obligations to make mandatory reports.

A family doctor told us that when she notified the college to which a male therapist in her community belonged that he had been identified by two of her patients as an abuser, and that she was making a mandatory report as required under the *RHPA*, the college responded with a letter saying that her information would be *"kept on file—-until the College deems it appropriate to take further action with respect to this matter."*

This kind of letter does not seem intended to encourage mandatory reporting or to foster shared responsibility in stopping the sexual abuse of patients.

FULL PARTY STATUS FOR COMPLAINANTS

Prince Edward Island's *An Act to Amend the Medical Act, 1997* stipulates, in section 30.1, that the council shall ensure that the complainant is afforded the option to be supported by a friend or **representative to make statements and submit evidence and to be represented by legal counsel in an inquiry** (emphasis added). Only full party status gives patients the same right as the member to appeal the decision of the panel to a court.

Nine years ago, we noted that complainants had party status in other administrative hearings, such as those conducted by the Human Rights Commission. We recommended that *"the patient deserves the right to be present throughout the hearing, to have legal counsel to receive and review evidence, and to cross-examine witnesses including the member."* Unfortunately, the granting of party status, though made optional, was not required by the *RHPA*.

As Professor Sanda Rodgers has noted:

> *"The failure to respond to this demand compromises the disciplinary process, privatizes the cost of regulation of health professionals, and allows for a continuation of the re-victimisation of which the process has been accused."* [15]

Patient after patient, including those whose complaints were verified by a panel and resulted in the member being disciplined, told us the process was so difficult and so damaging that they wished they had never gone to the college with their complaint. It is time that patients be given a fairer opportunity in these proceedings. There is no substitute for full party status.

Recommendations - Chapter Three

The New HPRAC Monitoring Team as a Catalyst for Implementation

Recommendation 7.0

7.0 HPRAC should establish a "Monitoring Team" chaired by a designate of HPRAC, to supervise and facilitate the development and implementation of any initiatives to deal with sexual abuse by health professionals, including recommendations that flow from this report, with a renewable term of five years; membership to include Ministry of Health appointees at least at the director level in the ministry, at least one member of the Special Task Force, two survivor/advocates working in the field of abuse prevention and/or victim support, and at least one executive officer of the PAC, with remuneration at least at the level of HPRAC members.

Recommendation 8.0

8.0 For the initial five year term of the HPRAC Monitoring Team, it will commission an empirical study to determine how many mandatory reports have been made since 1999, what was done by the college receiving the report, whether any further reports or complaints about the member have been received and what actions have been taken. Details as to best practices among colleges in Ontario and in other jurisdictions, especially Prince Edward Island and New Brunswick, are to be included with recommendations for ways to increase responsiveness to patient complaints in the interest of public safety.

Identifying Patients

Recommendation 9.0

9.0 The existing protection in section 85.3(4) of the *RHPA* Code must be upheld to ensure that a reporting member does not give the name of the patient complainant unless the member has the express, written consent of the patient.

IMMEDIATE REPORTING

RECOMMENDATION 10.0

10.0 Section 85.3(2) of the *RHPA* Code should be amended to the effect that mandatory reports should be made forthwith rather than within a 30-day period and that such a report should be immediately reviewed by the PAC, with an investigation triggered upon the receipt of any report which prompts reasonable suspicion that the member poses a risk of harm to patients, or upon the receipt of two reports of sexual abuse by a member.

ENFORCEMENT OF PENALTY FOR NOT REPORTING

RECOMMENDATION 11.0

11.0 Colleges must enforce the penalties specified in section 93(4) of the Code of a maximum fine of $25 000 on health professionals who fail to make a mandatory report of sexual abuse.

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

RECOMMENDATION 12.0

12.0 The *RHPA* Code should be amended to include a provision that requires the Health Professions Appeal and Review Board, when reviewing a decision of a Complaints Committee Panel, to render a decision within 120 days of receiving the request for review.

EVIDENTIARY RULES AT DISCIPLINE HEARINGS

RECOMMENDATION 13.0

13.0 Section 49 of the *RHPA* Code should be repealed and a new provision be added that states that the evidentiary rules governing college and PAC complaints and discipline hearings are governed by the Statutory Powers Procedures Act.

RECOMMENDATION 14.0

14.0 Section 36 (3) of the *RHPA* should be amended so that evidence on the findings, orders or decisions in disciplinary proceedings under the *RHPA* are admissible in civil proceedings.

FINES AND FUNDING FOR THERAPY

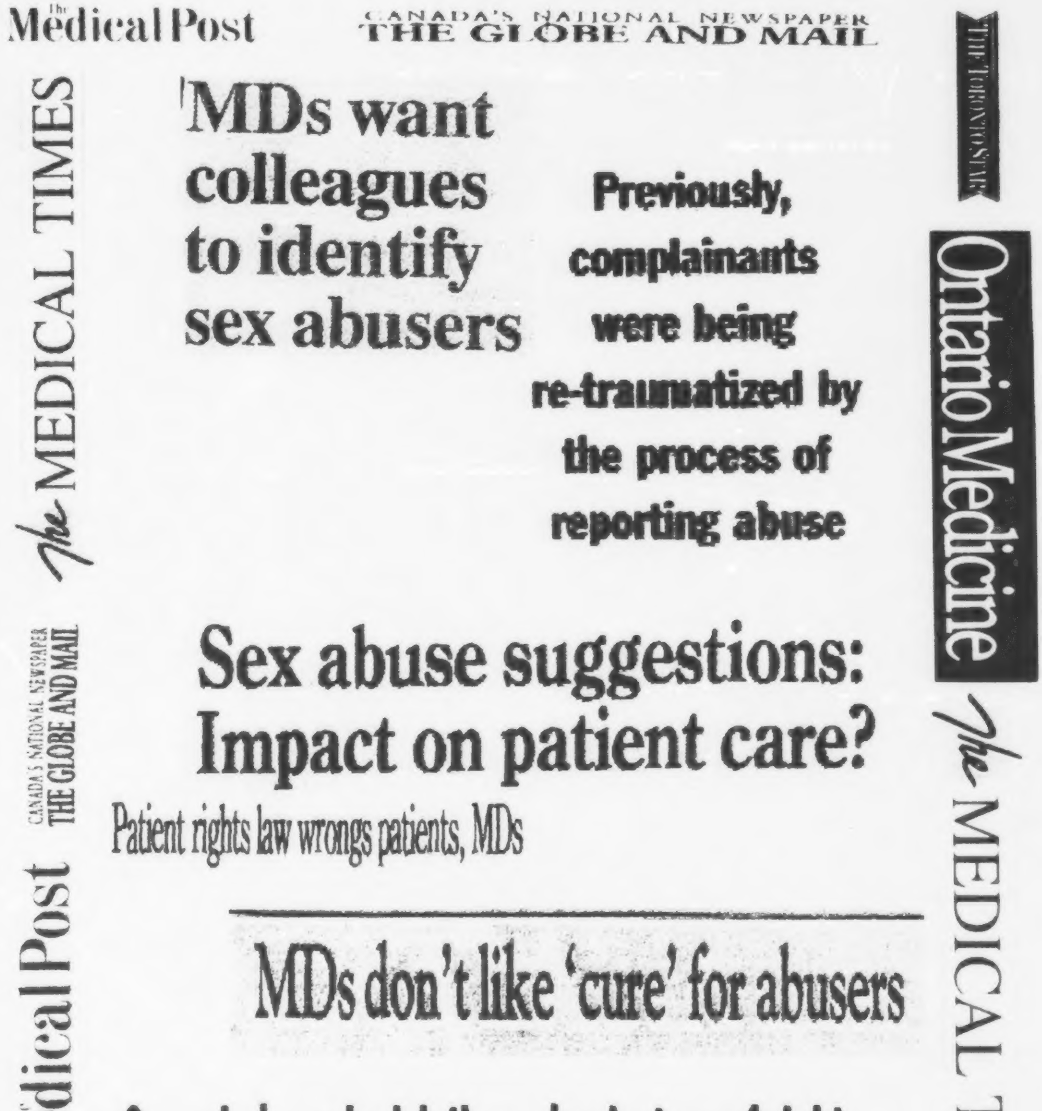
RECOMMENDATION 15.0

15.0 Provincial rules and legislation should be amended to ensure that any fines imposed on a member for the sexual abuse of a patient should be designated as a separate fund under the jurisdiction of the Public Access Centre, to be used for support to patients, including therapy and counselling for eligible patients.

15.1 Section 85.7 (4) and (10) of the *RHPA* Code should be amended so that interim funding for patients' therapy can be provided prior to the hearing stage, where the PAC determines that it is a meritorious claim.

CHAPTER 4

Impact of College Processes on Patients



The Medical Post

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

THE TORONTO STAR

The MEDICAL TIMES

'MDs want colleagues to identify sex abusers

Previously, complainants were being re-traumatized by the process of reporting abuse

Ontario Medicine

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

Sex abuse suggestions: Impact on patient care?

Patient rights law wrongs patients, MDs

The MEDICAL TIMES

The Medical Post

MDs don't like 'cure' for abusers

Sexual abuse legislation robs doctors of rights

Ontario Medicine

THE TORONTO STAR

The Medical Post

CHAPTER FOUR

Impact of College Processes on Patients

HEARINGS

At the request of the Honourable Elizabeth Witmer, Minister of Health and Long-Term Care for Ontario, the Task Force met privately with many patients, and we held a Public Hearing in Toronto on May 24, 2000. Notices for this hearing were published throughout Ontario (see Appendix II of this report). We heard unvarnished testimony from patients and their advocates about the impact of college processes and a transcript of the public hearing was prepared.

At the Public Hearing, Susan Vella,[16] a Toronto lawyer specialising in civil remedies for sexual violation, spoke on behalf of patients who are her clients. Members of the Task Force decided that the comprehensive information on impact that Ms. Vella brought to the hearing and her recommendations were so cogent that we have reproduced much of her testimony for readers of this report. The extensive quotes in Chapter 1, from patients Brenda and Janet and Janet's psychotherapist, are also from the transcript of the Public Hearing.

Susan Vella

> *"My clients have felt either unable to come, or unwilling to come, because they are embroiled in current legal proceedings or because it's just too difficult to come and say their statements in public.*
>
> *With the release of the task force's original report, the college became more accessible to patients alleging sexual misconduct by health professionals. As a result, more patients saw the college as an option and came forward with complaints, and more complaints made their way to the discipline hearing. But the health professionals' lobby—apparently led by funded legal counsel—alleged that the pendulum had swung too much in favour of the patients.*

Thereafter, the college made adjustments to the process, including letting go many of the investigators who had been part of a successful sexual abuse team and through hiring new legal counsel in-house. In addition, as a result, there has been a definite chilled environment, which has engulfed the college. The patients have noticed and their legal counsel have noticed too.

Particularly in the past four to five years, the proverbial pendulum has swung back in favour of a tangible bias against patients: so much so that many lawyers, including myself, cannot recommend that patients ever go to the college."

CASE PROFILE

"A patient was a victim of childhood incest and then, in her adolescence, she was sexually abused by her GP. As an adult, she went to another GP and disclosed her traumatic history. This GP was young (and) relatively inexperienced, but nonetheless engaged in extensive psychotherapy with the patient.

The doctor identified the problem, but thought he could handle it on his own. The result was that there were sexually charged sessions where very little was accomplished on the presenting issues of child and adolescent abuse. The patient believed she was in love and then felt extreme betrayal and upset and required even more therapy with a different professional, just to deal with the mishandling of the transference, before she could even deal with the original problems of incest and childhood abuse.

Patient files complaint with the college. Alleges improper sexualised conduct and exploitation of the relationship and negligent treatment. The college does a brief investigation and determines that there is no merit to the complaint and dismisses it without going forward to a discipline hearing. They saw no issue whatsoever worthy of a hearing.

We found out that the college had not even bothered to hire an expert GP to assess the methodology of the respondent doctor, or to assess the propriety of his conduct during these sessions. So, the patient now has to engage legal counsel and pay for it, and also has to engage an expert and appeal the college's decision not to send the matter forward to a hearing to what was then the Health Disciplines Board. The patient had to pay for all of this.

The review board had no difficulty finding the flaws in the investigation of the college, sent the matter back to the college, and gave directions as to how they should conduct their investigation, including hiring an expert (and) perhaps giving some advice about propriety of the conduct reflected in the doctor's own medical records."

ACCESS TO THE THERAPY FUND

"That's the second aspect of this scenario. The patient already had a validated complaint after (the) hearing (against) the doctor, who abused her as a teenager, but she could not access any of the therapy fund and I think that's a huge problem.

We wrote letters. We interacted. No funding, because apparently the view of the college at that time was that the acts of abuse predated the legislation or the establishment of the fund. Therefore, no funding would be extended.

Needless to say, this patient felt betrayed again, and this time by the college. And, had she not persisted and hired her own counsel and an expert, the case would have been closed, no questions asked.

*First recommendation. I think **there needs to be some kind of direction to the investigators and the college counsel that they are not to make credibility decisions at the investigatory level**. That is not their role. It does not conform (to) any type of procedural justice that I can think of.*

*Second, we need **better education for investigators, legal counsel and discipline committee members**. Why not have seminars and conferences like the criminal lawyers' association puts on for the judges on sexual assault (and) which reflects both doctors' and patients' perspectives? You can have advocates from both sides, but why not educate?*

*Third, there should be **an independent victim witness support person or advocate on staff at the college** or at least on retainer with the college—someone who would not be seen as (tainting) the investigation, which was the complaint of the doctors before. So, they are independent. They don't have any decision-making powers. What they do is...give support to the victim going through the process. We have that process in the criminal process with victim witness advocates. Why not in the college process?*

*Fourth, I think that **the college has to define and enforce standards for GPs practicing psychotherapy**. I am faced with GPs who 'pretend'—and that's my derogatory language—but pretend to practice psychotherapy when they don't know what the heck they're doing."*

INTERIM FUNDING FOR THERAPY

"Why not have interim funding for therapy? We do that at the Criminal Injuries Compensation Board. The Criminal Injuries Compensation Board has the ability to provide some interim funding for therapy before the claims are processed through a hearing if the board determines that it is a meritorious claim. Why not do it here?

I'm not asking for the (existing) budget to be increased. At least, this way, patients can have (their own) therapist there, and there are issues around the choice of a therapist that I think need to be respected from the patient's perspective. At least they will have someone in their corner helping them with psychological support. Why shouldn't they have that? You want to have empowered patients who are able to tell their story in an articulate and persuasive way on the stand. Otherwise this justice system isn't working.

*Next, **colleges need to provide, in plain language, an explanation of the RHPA and how it applies to their process**: what is entailed in filing a complaint; what is entailed in the investigation; what is the hearing about; what are their rights at hearings; issues around privilege over medical records. They should not be handed over, holus-bolus, because often there is irrelevant but highly private information which is again turned over to defence counsel.*

The Supreme Court of Canada has said in MA versus Ryan that (complete disclosure) is not required. Only relevant portions of records need to be turned over. But the patients don't know that. They're signing full release forms *saying go ahead. And that is a problem that is happening in the police process as well and there have been steps to rectify that. I don't know how satisfactory (it is), but at least it's been recognised."*

AMENDMENT TO THE *RHPA*

"The college must be encouraged to lobby for an amendment through section 36(3) and it's a very simple amendment that I would propose. The amendment would simply make any order or decision made in a discipline proceeding admissible in a civil proceeding. So, we protect their concerns, which is we keep out transcripts of the hearing, so that we deal with the issue of calling experts who don't want to be dragged into a civil process, and we keep out also investigation notes and those interviews.

I can tell you, the summary of interviews taken by investigators has caused plaintiffs on the stand in a civil trial nothing but grief, because inevitably the doctor's lawyer has it. There are inaccuracies in what's supposed to be a recording of an interview held between the college and the patient and it's not what the patient is saying on the stand. And she says, but I didn't revise that, I didn't review it. You know, that's a fine answer, but the judge is already formulating some concerns. 'Gee, it looks like you said something different.' So, they are using it as prior inconsistent statements.

Yes, we can get around that. We can say, no, it's not my statement, but the evidence is in, so to speak. So, I think there's value to keeping out all of the documents and transcripts. I think what we really need to have is the ability to advise the trial judge that there has been a full hearing on this matter. The doctor is fully represented. And that the same or similar allegations as are being put forward by the plaintiff, were validated by the college discipline hearing and vice versa. This would also leave it open for doctors to file evidence on an acquittal by the college. I'm not suggesting this is a one-way street. But the fact of the matter is that this generally prejudices the patient, not the doctor."

PATIENTS NEED FULL PARTY STATUS

*"Next, **accord patients party standing at the hearing**. This is not unprecedented. If a complainant files a complaint with the Ontario Human Rights Commission, there is commission counsel, but the complainant has party standing. That means they have a say in how the case is run. That means they get to call evidence. That means they get to cross-examine. That means they get to put forward the patient's perspective, which might be different from the college's. For example, on privilege issues, the college has no vested interest in protecting (the) privacy of patients. Patients do. They should make that argument. They are allowed to make that argument in criminal proceedings independently from Crown counsel."*

RECOMMENDATIONS - CHAPTER FOUR

MOST APPROPRIATE COMPLAINANT STATUS AND SUPPORT IN HEARINGS

RECOMMENDATION 16.0

16.0 It is recommended that the *RHPA* Code be amended to include the following provisions in sexual abuse cases:

a) all complainants should have the right to participate in the proceedings of any complaints or disciplinary hearings, as a full party;

b) all complainants should have the right to a support person of her choice at the expense of the PAC and the colleges, at all stages of the investigation, complaints process, and disciplinary hearings;

c) all complainants should have a right to testify behind a screen, by closed circuit television, or similar device that allows the complainant not to see an adverse party, if it is likely to help the complainant to give complete and accurate testimony or if it is in the best interests of the complainant;

d) all complainants should have the opportunity, in accordance with current *RHPA* provisions, where the member is found guilty, to submit a victim impact statement and not to be cross-examined on that statement, such statement to be taken into account in the assessment of a remedy or penalty;[15]

e) A videotape of an interview with the complainant may be admitted in evidence if the complainant, while testifying, adopts the content of the videotape; and

f) Under no circumstances, can the alleged perpetrator of the sexual abuse personally cross-examine the complainant.

EXPERT WITNESSES

RECOMMENDATION 17.0

17.0 The PAC and colleges must develop criteria for selection of experts to present evidence at complaints, discipline and reinstatement proceedings, to ensure that expert witnesses have clearly demonstrated expertise in the dynamics and impact of sexual abuse by health care professionals.

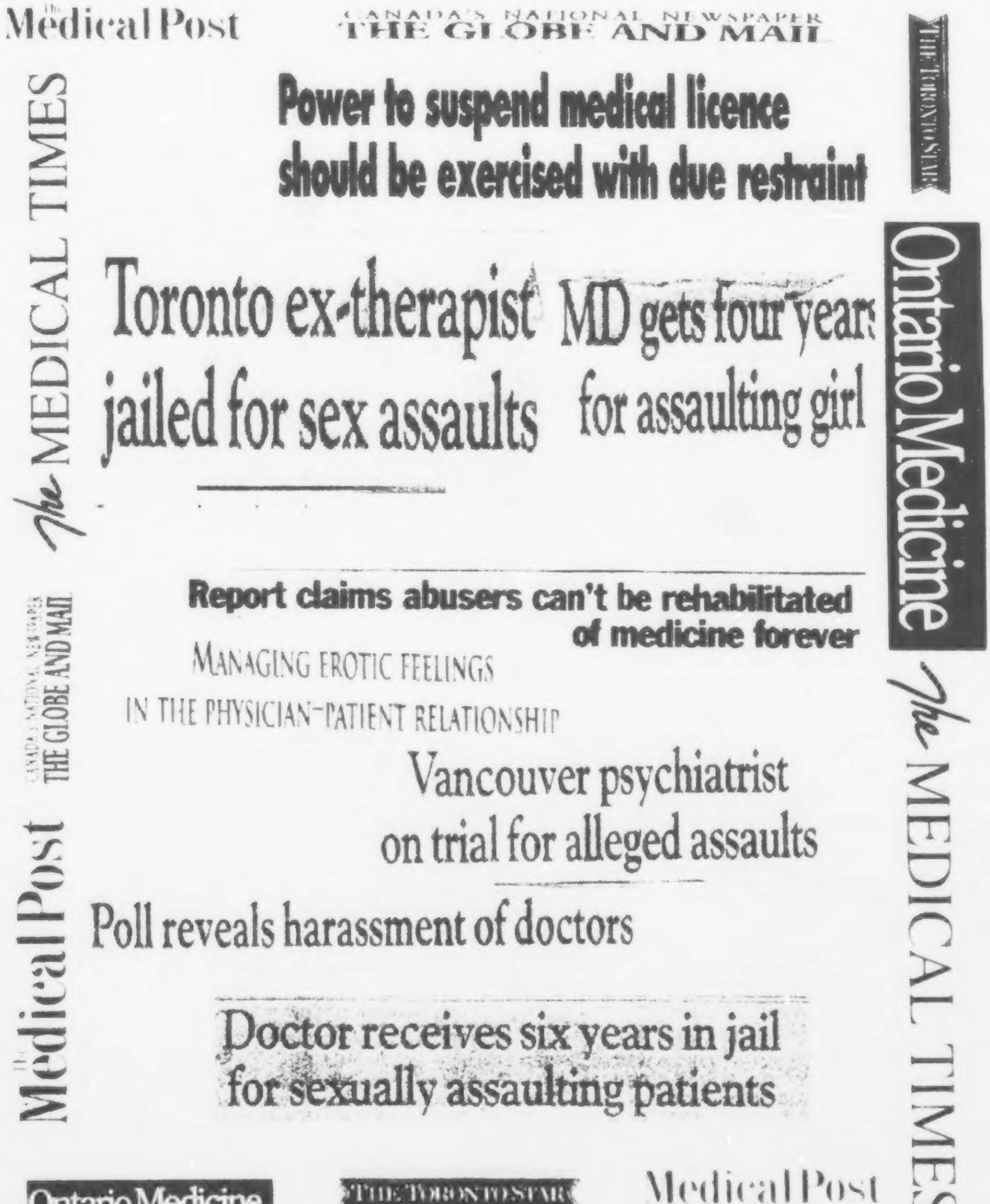
FAST TRACKING SEXUAL ABUSE CASES

RECOMMENDATION 18.0

18.0 All discipline cases of sexual abuse by health care professionals should be given priority and fast tracked by the colleges.

CHAPTER 5

Deterrents and Penalties



The Medical Post

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THE TORONTO STAR

The MEDICAL TIMES

Power to suspend medical licence should be exercised with due restraint

Toronto ex-therapist jailed for sex assaults

MD gets four years for assaulting girl

Ontario Medicine

Report claims abusers can't be rehabilitated

of medicine forever

MANAGING EROTIC FEELINGS IN THE PHYSICIAN–PATIENT RELATIONSHIP

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

Vancouver psychiatrist on trial for alleged assaults

The Medical Post

Poll reveals harassment of doctors

The MEDICAL TIMES

Doctor receives six years in jail for sexually assaulting patients

Ontario Medicine

THE TORONTO STAR

Medical Post

CHAPTER FIVE

Deterrents and Penalties

SEXUAL CONTACT GUIDELINES AS DETERRENCE

The 1999 HPRAC survey that is discussed in detail in Chapter 2 is the only one to have surveyed admission of sexual contact across disciplines in Ontario, but the sample size was relatively small. Nevertheless, this survey and those that focus on physicians[17] indicate that a small but significant percentage of Canadian health professionals are willing to admit to sexual encounters with patients.

For example, 3% of male respondents to a survey of 618 Canadian obstetrician-gynaecologists, with a 78% response rate, acknowledged having a 'sexual encounter' with a current patient while 3 % admitted to a sexual encounter with a former patient.[18]

One half of one percent of those who responded to a 1996 survey of 599 emergency physicians admitted to 'sexual encounters' with current patients, while 6.2% said they had been sexually involved with a former patient. Thirty six per cent of sexual encounters with former patients reportedly took place in 'an office': 39% in another 'medical setting.'[19]

Seventy nine per cent of those who responded to this survey believed it was appropriate for a physician to request a date with a former patient that he had first dealt with in the emergency department and later happened to meet in non-professional setting, such as at a club or party. However, only 21% of respondents believed it was appropriate for a physician deliberately to request a social meeting with a former patient after the patient was discharged.

The authors of this study indicate that 'when there is a potential for abuse', a one year waiting period may not be adequate to prevent it and that, when a relationship **is** appropriate, it would be unfair to impose this interval. In their view, it is important to make a distinction between encounters in a non-patient capacity (before or after the emergency department visit) and patients who are known only as patients. They believe this distinction can form a clear and logical basis for creating new guidelines since the vague regulatory guidelines currently in place have failed to dispel confusion regarding what is acceptable social behaviour for physicians providing emergency care.

The Task Force recommends that sexual contact guidelines should be made clear and enforceable. Please see our Recommendation 19 at the end of this chapter for more detail.

TRANSFERENCE

The Minister asked us to comment on what patients had to say about penalties applied when "a member claims that the sexual relations between the member and the client/patient are consensual." (See Question 5 at the beginning of this report.) In order to understand how such a claim could be made, the dynamics of sexual abuse have to be understood.

In Chapter I, Nora told us how she was enthralled with her therapist and how convinced she was of his love for her. Few of us, including many of the respondents in the Canadian physician surveys referenced above, have a thorough understanding of the dynamics of transference. Thus the issue of when consent **can** be given is integral to answering the Minister's question.

Given the power imbalance between professionals and patients, the equality necessary for genuine consent is not present. Although the level of the power imbalance varies from health profession to health profession, it is **always** present and therefore does not make consent possible. This was recognised by the Parliament of Canada in amendments to the sexual assault provisions of the *Criminal Code of Canada*, which include *'consent is never a defence'* when a trust relationship is found to exist.

We recommend the following statement on transference and relationship boundaries between health professionals and former patients.

> *"From our point of view, it is very difficult to support any particular time after which it becomes ethically permissible to become romantically involved with an ex-patient. Rather, two other issues are paramount:*
>
> *1. whether a professional-patient relationship that places the patient in a vulnerable position ever evolved; and*
>
> *2. whether there is capacity for mutual consent.*
>
> *These issues are removed from time elements and are much more related to concepts of transference and its effects on idealisation, identification and dependence. All therapeutic encounters are evocative of transference feelings. It is therefore logical to presume that there is never a time frame within which mutual consent would be possible once a professional-patient relationship is established. Romantic involvement would always imply a breach of trust."*[20]

As the expert witness in Nora's case so eloquently said:

"(Nora) could not have made a free choice to consent in sexual

> *relationship with (her therapist). She was in a sexual relationship with a man who had power over her psychological state of mind and her treatment process. He had initiated erotic contact after a process of grooming her for exploitation and slowly eroding her personal, physical and psychological boundaries and implying that she was special to him and that he 'loved her although he was not in love with her.*
>
> *(Nora) was in the throes of transference of a love more analogous to that for a father than that for a husband or lover. She was confused, anxious and vulnerable to him and afraid that, if she displeased him, she would lose him and thereby lose not only his attention but also her treatment for the emotional pain that originally brought her to him. There was a power, physical size and social status differential that placed (Nora) at a distinct disadvantage to (her therapist). In no way could she have freely consented to a sexual relationship with him."*

We explore this issue further in the discussion that follows about the penalty of mandatory revocation by comparing two recent decisions of colleges where the panel members have demonstrated substantially different views: the *Melunsky* decision by the College of Physiotherapists, appealed to the courts, and the *Mussani* decision by the College of Physicians and Surgeons of Ontario, currently under appeal.

PENALTIES

Since the Minister asked us the question about penalties in "consensual" relationships, these two very different cases that focus on the mandatory revocation penalty in the *RHPA* have been released. We have reviewed these decisions and it is our recommendation that the penalty of mandatory revocation should be extended to cases where the health professional is found to have engaged in a recurrent pattern of sexual abuse, as per our Recommendations 20 and 21 at the end of this chapter.

Please use the summary of the provisions of the *RHPA* and its *Code* in Appendix IV to assist in understanding the references to particular sections of the legislation.

COLLEGE OF PHYSIOTHERAPISTS CASE

In a series of hearings culminating in the recent Court of Appeal decision in *College of Physiotherapists v. Melunsky 1998 Disciplinary Panel*, a physiotherapist who treated a patient, Mr. M., entered into a personal and sexual relationship with him, which included sexual intercourse and marriage. The disciplinary panel of the college found that the sexual intercourse took place prior to the termination of the professional relationship. An expert witness gave testimony on boundary violations and the impact on patients of establishing personal and sexual relationships with practitioners.

Clearly, this behaviour fell within the definition of sexual abuse in section 1(3)(a) of the *RHPA Code*. In cases such as this, there is a mandatory penalty of 5 years revocation under section 51(5)(2). But in this case, Ms. Melunsky's peers on the college panel opted not to apply the *RHPA*, deciding that revocation would constitute cruel and unusual punishment under section 12 of the *Canadian Charter of Rights and Freedoms, (the Charter)*, which is part of our country's constitution. Instead, the College of Physiotherapists panel ordered that the member's certificate of registration be suspended for a period of 6 months and that the member appear before the committee for a reprimand.

In 1999, the member appealed the Discipline Committee's decision with respect to the finding and penalty to the Divisional Court. The Court upheld the finding of professional misconduct but set aside the panel's decision as to penalty. The penalty was reduced to an oral reprimand and the court gave no written reasons for its extraordinary move to ignore the legislative direction for mandatory revocation in its decision. The College requested permission to appeal the Divisional Court's decision on penalty to the Court of Appeal. In April 1999, the College was advised that the Court of Appeal would not hear this case.

In the opinion of the task force, the panel and court decisions in this case are an example of the urgent need for developing educational programs for judges on the reality of dynamics in sexual abuse. We recommend creating The Public Access Centre, discussed in Chapter 2 to deliver thorough, consistent information and training to members of colleges on transference, boundaries and the impact of sexual abuse on patients.

Sexual contact with patients in the *Melunsky* case has been treated as a matter of personal preference, not as a question of professional standards. We think the issues at stake are much larger than this.

A decision by a court in which the issues are more knowledgeably canvassed and in which judges give their reasoning in writing will be welcome, but must not be a cause for delay in taking action now.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO CASE

A positive contrast to the Melunsky case can be found in the recently released decision of the Discipline Committee of the College of Physicians and Surgeons in the *Mussani* case.[21] In this CPSO decision, the circumstances of the Melunsky case are reviewed, noting that *"No mention was made by the Court of the discipline committee's disregard for the mandatory revocation provision, and it is not clear that this matter was ever brought to the attention of the Divisional Court."*

The CPSO Discipline Committee noted that no cross-appeal was launched by the College of Physiotherapists and no one challenged the finding of the Discipline Committee that the five-year mandatory licence revocation contravened section 12 of the Charter. The Court only reviewed how the Discipline Committee exercised its discretion.

In the *Mussani* case, the Discipline Committee of the College of Physicians and Surgeons found Dr. Mussani guilty of sexually abusing two of his patients. From 1992-1994, the physician had sexual encounters, including sexual intercourse, with a patient in his office, in their respective homes, and in other locations. The patient had marital problems and Dr. Mussani provided counselling and psychotherapy. The patient became pregnant. It was uncertain whether Dr. Mussani or the patient's husband had impregnated her. Dr. Mussani arranged for an abortion. In 1994, the doctor sexually abused another patient by kissing her in a sexual manner in his office.

In its decision, the Discipline Committee ("the Committee") canvassed many of the key questions raised with our task force: mandatory revocation, constitutional rights, the fiduciary duties of a health professional, and implementing the zero tolerance standard for sexual abuse cases. The committee acknowledged heightened awareness in the early 1990's in the profession "regarding the unacceptability of any sexual contact between doctors and patients". The fiduciary relationship between the patient and the physician was examined and it was found that, in this case, there was a "serious breach of trust". The committee noted that the Ontario Medical Association subscribes to the notion of zero tolerance of sexual abuse between doctors and patients. The Committee also made the observation "that the previous legislation, which afforded discretionary powers to Discipline Committees regarding revocation of doctors' licences for sexual offences, did not accomplish the goal of abolishing such behaviour".

In a unanimous decision, the Discipline Committee decided that revocation with a recorded reprimand was the only appropriate penalty. The mandatory revocation penalty in section 51 (5) of the *RHPA Code* was examined by the Discipline Committee in the context of the *Canadian Charter of Rights and Freedoms* and held that section 51(5) does not violate section 7,12, or 2(d) of the *Charter*. In discussing the right conveyed by section 2(d) of the Charter, "freedom of association", the Committee accepted the proposition that this section protects an individual's right to participate in collective activity and that the section addresses social freedom of association, not sexual intercourse.

The CPSO committee in *Mussani* differed with the disciplinary panel in the Melunsky case, concluding that " the decision is of very little assistance" and noting that:

> *"The Discipline Committee has found Dr. Mussani guilty of sexually abusing a patient. If subsection 51 (5) of the Code is given force and effect, the Discipline Committee must revoke Dr. Mussani's certificate of registration based on its findings. That is to say, the Discipline Committee may not exercise discretion in the penalty, even if for some reason, it did not consider revocation appropriate." (at page 12)*
>
> *"Having considered the authorities, the Committee is not persuaded that the right to enter into a sexual relationship is a right protected by section 7 of the Charter." (at page. 14)*

MANDATORY REVOCATION

The patients we heard from, in public and in private, adamantly stated that the primary reason for making a complaint was that they knew the abusing health care provider was a continuing danger to others. Many patients told us that they made a complaint only after learning that the health care provider had also abused others. Most of them thought the damage they experienced was life diminishing. Patients' experience of the severity of harm created and their concern about risk to other patients produced strong, clear support for mandatory revocation of a member's license to practice upon being found guilty. This view is strongly supported by the recent decision of the CPSO Discipline Committee in *Mussani* where the value of the mandatory revocation penalty in the *RHPA*, is discussed as follows.

> *"While the Committee is prepared to accept that Section 12 (of the Canadian Charter of Rights and Freedoms) may apply to professional discipline hearings, it was not persuaded that the penalty of revocation was grossly disproportionate to the offence. Sexual abuse of patients is a very serious matter which is deserving of a very serious penalty. A doctor does not have an unconditional right to practise medicine and it is appropriate that the right be circumscribed (by way of mandatory revocation) if the doctor sexually abuses a patient. Such a penalty, while severe, protects the public and the integrity of the profession." (at page 18)*

RECOMMENDATIONS - CHAPTER FIVE

SEXUAL CONTACT GUIDELINES

RECOMMENDATION 19.0

19.0 The *RHPA* already specifies no sexual contact between members and their patients, but it should be amended to specify clear boundaries for sexual contact between members and their former patients, as follows:

a) that a member must not have sexual contact with a former patient for a period of two years following the date of last professional contact with that patient, whether or not the member has formally terminated the professional relationship, provided that the member should never have sexual contact in cases where the former patient

   i) was a minor during the period of professional care; or

   ii) was suffering a judgment impairing disorder during the period of professional care; and

b) that a member must never have sexual contact with a former patient when the professional relationship was psychotherapeutic in nature.

PENALTIES: ZERO TOLERANCE PRINCIPLES

RECOMMENDATION 20.0

20.0 The *RHPA* Code should be amended so that the penalties imposed in cases of sexual abuse are consistent with the Zero Tolerance standard and act as a deterrent to ensure that the public is protected. To this end, the following principles should be in amendments to the *RHPA Code* to guide in the determination of penalties:

a) specific deterrence of the member of engaging in further sexual abuse;

b) general deterrence of other members of the profession;

c) denunciation by society of the conduct; and

d) the need to maintain the public's confidence in the integrity of each profession's ability to properly supervise the conduct of its members.

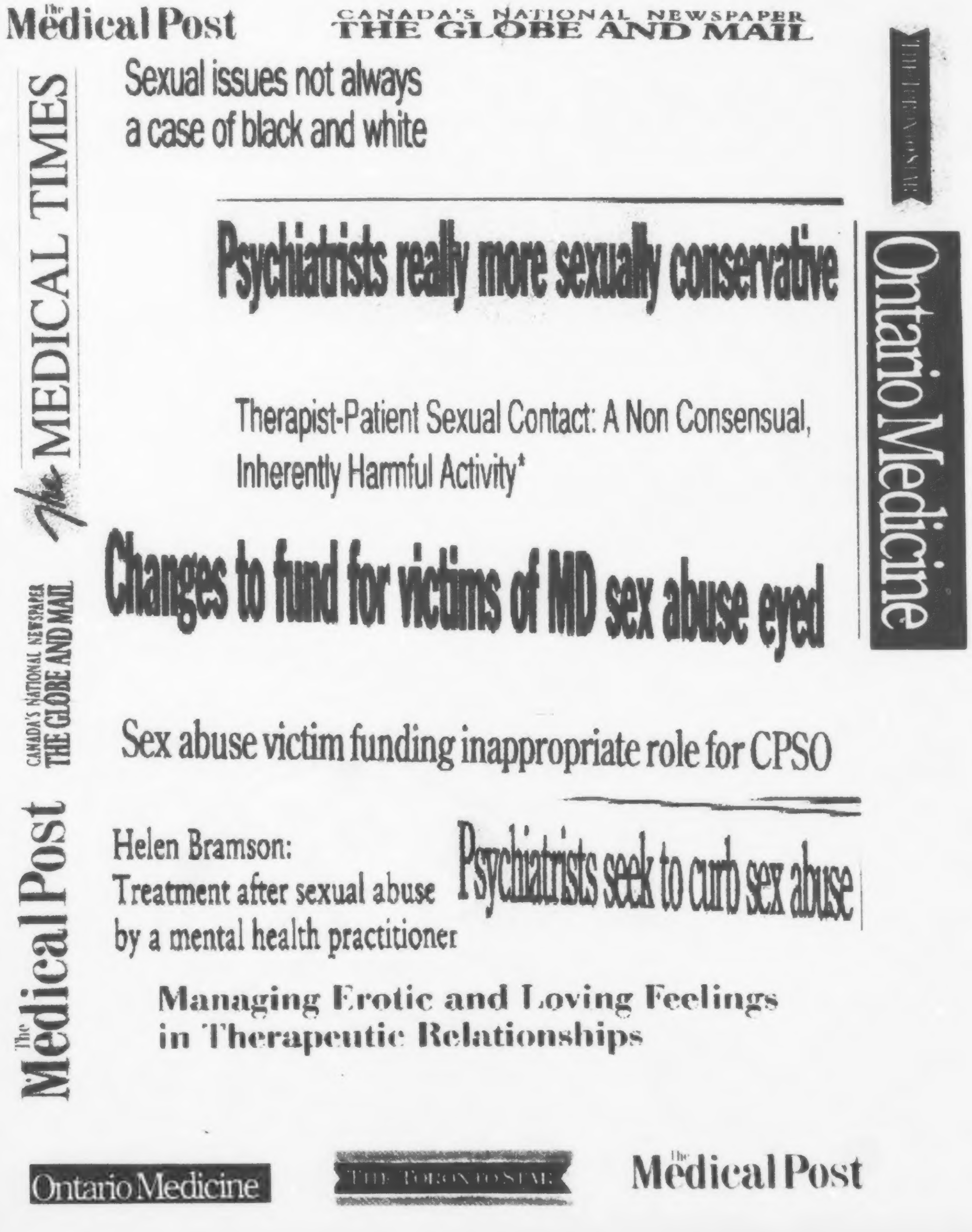
Mandatory Revocation where Recurrent Pattern

Recommendation 21.0

21.0 The *RHPA* Code should be amended to include mandatory revocation of the certificate of registration of a member who has been found guilty of a recurrent pattern of sexual abuse under section 1(3) (b) or (c) for a period of time to be stipulated by the discipline panel.

CHAPTER 6

Mediation, Support and Therapy for Patients



The Medical Post

CANADA'S NATIONAL NEWSPAPER
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The MEDICAL TIMES

Sexual issues not always a case of black and white

THE TORONTO STAR

Psychiatrists really more sexually conservative

Ontario Medicine

Therapist-Patient Sexual Contact: A Non Consensual, Inherently Harmful Activity*

Changes to fund for victims of MD sex abuse eyed

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

Sex abuse victim funding inappropriate role for CPSO

The Medical Post

Helen Bramson:
Treatment after sexual abuse by a mental health practitioner

Psychiatrists seek to curb sex abuse

Managing Erotic and Loving Feelings in Therapeutic Relationships

Ontario Medicine

THE TORONTO STAR

The Medical Post

CHAPTER SIX

Mediation, Support and Therapy for Patients

ELIGIBILITY AND SCOPE FOR THERAPY FUNDING

The statement of purpose in the *RHPA Code* is: *"to encourage reporting of (sexual) abuse, to provide funding for the therapy and counselling for patients who have been sexually abused by members..."*

However, we have found that the regulations to the *RHPA* are not delivering the intended results. When patients read the legislation, they anticipate being eligible for up to $10,000 to help cover the cost of recovering from sexual abuse. We could find no college that has provided funding any where close to this level.

At the present time, there is no access to funding for a patient whose complaint did not proceed to a formal hearing, regardless of its merits or the reason for not proceeding. As the legislation stands, there is extremely limited access to funding for therapy and counselling. If a plea bargain is reached, a member voluntarily resigns his or her license, or the college decides not to proceed with the complaint, the complainant is denied access to counselling.

These conditions are extremely distressful and only add to the trauma and frustration experienced by complainants. The following statements are from private submission made to HPRAC by survivors of sexual abuse. In the following statement, the survivor discusses the delay in receiving funds, as well as the lack of funds for counselling her spouse, who experienced secondary or vicarious dramatisation.

"I personally found the time between reporting the abuse and the hearing to be extremely stressful and, as such, needed a great deal of health care to keep functioning.

> It would have been of great assistance if the funds could have been available retroactive to the date when I first reported the abuse to one of my health care workers, or at least to when I spoke to the college investigator. (In order) for me to take advantage of the funds money, I must arrange for childcare for every visit to a therapist. This is very costly and there is no provision for financial help from the fund. As well, (because of) the way the fund is managed, there is no money available for my husband to seek therapy that he may require around the issue."

Even though the accused lost his license, the complainant had to endure a delay in receiving the necessary funding for therapy. In addition, the funding that **is** allowed does not provide for expenses related to seeking the therapy. This makes the access to therapy quite difficult in some cases, including those cases where the abused person must arrange for childcare, transportation or long distance communications.

Another patient who reported sexual abuse by a health care provider said:

> "The time period between the abuse and the award of funding was not covered. During this very stressful period, when the therapy was needed most, it was available only at our own considerable expense. Reimbursement for the therapy received during this time would provide great relief for victims. Worrying about the financial aspect of healing (because) of professional abuse (places) an extra intolerable burden on victims.
>
> My other area of concern relates to the method of funding. As a victim, I would prefer a direct, lump sum payment to the victim. There is some reluctance by health care professionals to treat victims because of the paperwork involved. This reduces the selection of treatments and practitioners to those willing and financially able to work within the system. As the goal is to get the victim's health restored quickly, a more user-friendly funding system would greatly reduce the stress and improve and speed the healing process."

This person is rightly concerned about the fact that there is a reluctance by many providers of counselling to give care to victims of sexual abuse by a health provider because there is a great deal of paperwork involved in getting payment for the treatment and advocating, without financial compensation, on his or her behalf. Potentially, this can severely hamper access to treatment, as the person may not be able to find a health care provider suitable for her needs. She is limited to those providers who are willing to go through the red-tape of filing claims through the college.

A third complainant, and one who is also a member governed by the *RHPA* says:

> "I feel strongly that funds should be made available retroactively from the date of abuse. The stress involved in coming to terms with what happened, making decisions about putting in a complaint, and dealing with the process of investigation is immeasurable."

This complainant also raised the point that those who have been sexually abused by a health care professional require treatment; not just **after** the disciplinary proceeding, but also from the date the incident occurred. However, there are no provisions for funding during this time. At the very least, funds need to be paid retroactively to the complainant and a clear commitment needs to be made on which the patient can rely.

According to the College of Physicians and Surgeons, the current legislation states that if the Disciplinary Committee levies any fines, those fines are paid to the provincial government. This is why the college recommends that, for cases of sexual abuse, any fines levied should be kept by the college and put into a separate fund that could be used for providing therapy or counselling to sexual abuse victims.

This recommendation is consistent with section 38.4 of Prince Edward Island's An Act to Amend the Medical Act, 1997, which states that *"where a member is found guilty of sexual abuse, the council may, as part of the remedy, levy a fine to be used for the purpose of paying the costs of therapy or counselling which the council believes to be necessary for the victim of sexual abuse."*

One college has taken a proactive approach by hiring a company to survey complainants and respondents (college members) concerning the complaints process. Decima will also interview patients who have applied for therapy will also be interviewed concerning their views of the application process.

MEDIATION/ALTERNATIVE DISPUTE RESOLUTION

In her letter of January 7, 2000, the Minister asked the Task Force: *"Under what circumstances is mediation being used by Colleges in the complaints and discipline process related to sexual abuse? Are complainants satisfied with the mediation process?"* (Question 8, reprinted at the beginning of this report).

The following points are raised in the book by Richard Steinecke,:[22]

1. colleges which use this process may be subordinating their public protection mandate to save money;
2. serious allegations ought to be dealt with through discipline in order to deter practitioners and express disapproval of the alleged conduct;
3. complainants may be vulnerable in the mediation process because they may not have a full appreciation of their right to insist that the matter be dealt with through the discipline route; are not always represented by lawyers; and may not have the same confidence and ability as members and lawyers to express themselves; and
4. the outcome of mediation, which is not often published and does not identify the member alleged to have committed a sexual offence, makes it difficult to scrutinise the process.

We recommend against using mediation/ADR in sexual abuse cases. The *RHPA* makes no specific provision that relates to the use of mediation or alternative dispute resolution (ADR). This is a process that attempts to resolve complaints/disputes to the mutual satisfaction of both parties without resorting to lengthy reviews or hearings. Clearly this process has significant appeal to colleges for its potential in "cost containment". But information about the outcome of the mediation/ADR process is not included in the College Register and is not made available to the public.

The College of Occupational Therapists said in its submission to HPRAC in December 1999 that, in certain circumstances, the outcome of ADR negotiations should be placed on the public portion of the college register since the public has every right to know if a health practitioner is practicing under supervision because of an undertaking or an ADR settlement.

In the roundtable discussion that the task force had with representatives of the colleges in May of this year, Dr. Dody Beinenstock, a member of the governing council of the College of Physicians and Surgeons of Ontario told the task force that the CPSO, *"did a pilot project, ... with four cases, and decided that this was not a route for sexual abuse cases. We do not use formal ADR for sexual abuse cases any more, period."*

One other college has expressed its belief that ADR should not be used for sexual abuse cases, since complainants are vulnerable and do not believe that it is an open and thorough process. This college also believes that members of the public, including patients who are potential complainants, need to know that self-regulation is not a private process. Nevertheless, there is a certain ill-founded optimism among some of the colleges that mediation or ADR in sexual abuse cases has "potential". We cautioned the CPSO in 1991 that this approach is not in the interests of the patient or the public. This time, reports that we received from patients about their experiences with how colleges are using mediation in sexual abuse cases underscores our advice that it is not and cannot be made into a fair resolution process because of transference and other aspects of the power imbalance embedded therein.

HEATHER

'Heather', having initiated her complaint to the college in 1994, decided to accept the college's suggestion to try mediation to resolve her complaint. The member admitted to prescribing anti-depressant medication and acts of sexual contact with Heather while he was her therapist. She wrote of her experience after the mediation failed. Heather and her husband had signed a 'gag agreement', on the understanding that if the mediation did not succeed, she could re-enter the disciplinary process and, because of the member's admissions, that the case would proceed to the Discipline Committee.

Heather explained that:

"I allowed the college to give me the mediation options based on their commitment to take it on to discipline should the mediation fail to produce results. When this option was presented, I felt it was a good one because I wanted to confront the (health care provider) face to face and I had high hopes for us to reach an agreement. I also felt strongly about trying mediation because of our religious convictions.

The actual confrontation part of the mediation was a positive experience for me, but there were major disappointments with the process of the mediation, the mediator himself, and, of course, the unsatisfactory outcome. Now the test will be to see if the college holds their commitment to take it on to discipline. I don't expect to know this anytime soon because of their extreme tardiness."

Heather wrote to the college making her position clear:

> *"... my desires concerning mediation have not been adequately met.[I believe the member and the college] just want to treat this situation as a bad dream. I myself have often wanted to do the same. I didn't realise this at the time but, after the mediation, I had a considerable emotional setback and I wanted to make everything work to please the (member). For a brief time during one point in the mediation, I was left alone with (the member) us everyone left the room. During this time, we exchanged some words and he affirmed me in a way that made me feel linked to him again and definitely more desiring to please him."*

After reviewing the facts of Heather's case, and finding them to be clearly different from what the college was saying publicly about its approach to mediation, the Task Force Chair consulted expert practitioners in mediation to discuss the use of mediation in such cases.[23]

The mediators made a number of general points, with one key premise - **"safety is the most important criterion"**- and that:

- mediation must not be used in a way that would undermine patient or public safety;
- a responsible mediator would discourage mediation in cases of obvious transference;
- each case requires a very through screening process with specially trained mediators if sexual dynamics are present in the complaint; and
- skilled mediators would never meet at the same time with the two parties in such cases."

Many of the general points made by the mediation experts are echoed in what patients report. Heather made the following plea to the college.

> *"Please, if you are ever in another mediation, do ensure that the patient is never left alone with the member. (The patient) is still vulnerable. This vulnerability makes being firm and clear, in my case, very difficult."*

Recently, more than two years after Heather was left alone by the college to face her therapist in mediation which ultimately failed, she received a letter from the college telling her that the Complaints Committee refused to refer her complaint to a disciplinary panel.

In a letter full of internal contradictions, the college gave Heather the news that it was not going to honour its commitment to her, made to her as part of the college's encouragement to her to enter mediation. The Task Force cites this case as a disturbing and current example of how inappropriate mediation is, and also as an illustration of the devaluation of patients in the approach taken by some colleges to sexual abuse by health professionals. The college correspondence in Heather's case is replete with promises. Empathy and flexibility are extended by college members to their colleague.

The most recent letter from the college to Heather noted that, from *"the outset the Complaints Committee has been concerned [that the member]* *pursued this relationship, ...[that the member had a]...problem with boundary issues."* Yet, although the Complaints Committee noted that *"even by the standards applicable when the sexual relationship began,"* prior to the *RHPA* a practitioner *"using his or her good judgment would not have entered into such a relationship with a patient,"* the committee refused to send the matter to the Discipline Committee.

The Complaints Committee acknowledged that the member's charts were reviewed, and seems to congratulate the member for acknowledging transference issues in his charts. The lens through which Committee members viewed this case seems narrowed to their colleague's perspective and to his career potential, with little regard or comment on the long-term damage experienced by the patient.

The Committee noted that a review of their colleague's charts assured the members that he *"was cognisant of these issues and sought to address them appropriately. After the therapeutic relationship was terminated, [the member] recognised the complexity of pursuing a relationship with a former patient."*

And yet he **did** "pursue" the "relationship". As Heather said to the Task Force:

"One day I was his patient and the next day, I was his former patient."

It is perplexing to read, how in part of their decision the members of the committee note that the member admitted that there was an "overlap" in time when the patient was under his care and he was having sexual contact with her and prescribing medication for her, and that he *"did ultimately terminate his romantic relationship largely due to the climate at the time"* (post 1991 Task Force), yet they fail to address the concerns of the patient, using the euphemism "romantic relationship" to describe their colleague's conduct. The committee members support their decision on the basis that the member signed an undertaking to take some boundary courses, to pay all costs of the course, and to follow up on all advice he has received.

In the correspondence reviewed by members of the task force, Heather stated her clear reliance on the college's promise that her case would go to a discipline panel if the mediation failed. Yet the members of the committee support their rejection by noting that the patient did not wish to proceed and the patient could not be found. The task force determined that while the patient had moved, a contact number used previously by the college is unchanged. The Complaints Committee goes so far as to say in its decision that "we are of the view that it is not in the public interest" to refer the case on to discipline.

The college Complaints Committee in this case did not honour a commitment made by college staff members to forward the matter to the Discipline Committee in the event of an unsuccessful mediation.

In reading this latest letter from the college, Heather noticed the motto of the college and said that, based on her years of experience with the college, *"protecting the [member] and misguiding the public is their real motto. I feel disposable; more beat up after than when I started."*

Heather's case is a cogent demonstration of a concern raised by the Director of Legal Services of the Barbara Schlifer Commemorative Clinic, Mary Lou Fassel, who has represented a number of patients in college processes, *"it should be kept in mind that the 'other' party a woman perceives herself up against in mediation may be the college itself and not just the professional and his legal representative."*[24]

RECOMMENDATIONS - CHAPTER SIX

FUNDING FOR THERAPY EXTENDED

RECOMMENDATION 22.0

22.0 A regulation pursuant to section 85.7 of the *RHPA Code* should be made to clarify that funds are to be provided to the patient / complainant in a sexual abuse complaint to cover the cost of medications, childcare, and reasonable travel/accommodation expenses associated with accessing therapy related to the sexual abuse.

RECOMMENDATION 23.0

23.0 The *RHPA Code* should be amended to clarify that funding for therapy can be retroactive so that the complainant may be compensated for therapy received prior to the hearing for problems arising from sexual abuse by a member; and to ensure that the proceeds from fines for sexual abuse are directed to funding therapy for victims.

RECOMMENDATION 24.0

24.0 A regulation pursuant to the *RHPA* should stipulate that a patient is also eligible for funding for therapy or counselling if:

a) there is an admission made by a member in a statement to the College that the member sexually abused the patient;

b) the member has been convicted under the Criminal Code of Canada of sexually assaulting a person while that person was a patient of the member; or

c) the Public Access Centre or whatever agency is responsible for a decision, determines that there is sufficient evidence to support a reasonable belief that the patient was sexually abused by a member.

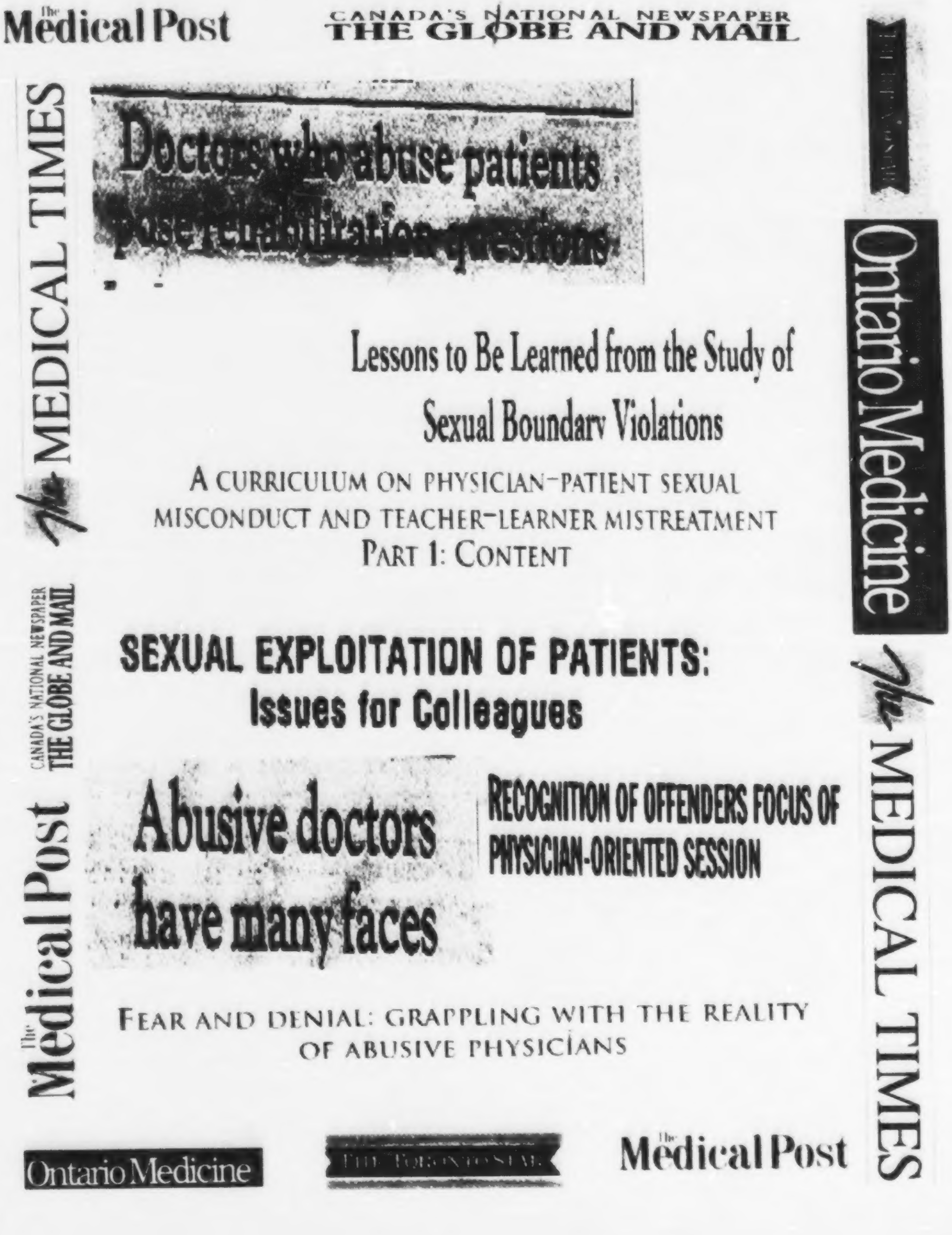
NO USE OF MEDIATION / ADR

RECOMMENDATION 25.0

25.0 The *RHPA* Code should be amended to state that any procedures considered to be Alternative Dispute Resolution or Mediation are not to be used to attempt to resolve complaints of sexual abuse.

CHAPTER 7

Education and Training



The Medical Post

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

The MEDICAL TIMES

Doctors who abuse patients pose rehabilitation questions

THE TORONTO STAR

Ontario Medicine

Lessons to Be Learned from the Study of Sexual Boundary Violations

A CURRICULUM ON PHYSICIAN-PATIENT SEXUAL MISCONDUCT AND TEACHER-LEARNER MISTREATMENT
PART 1: CONTENT

CANADA'S NATIONAL NEWSPAPER
THE GLOBE AND MAIL

SEXUAL EXPLOITATION OF PATIENTS:
Issues for Colleagues

The MEDICAL TIMES

The Medical Post

Abusive doctors have many faces

RECOGNITION OF OFFENDERS FOCUS OF PHYSICIAN-ORIENTED SESSION

FEAR AND DENIAL: GRAPPLING WITH THE REALITY OF ABUSIVE PHYSICIANS

Ontario Medicine

THE TORONTO STAR

The Medical Post

CHAPTER SEVEN

Education and Training

INFORMATION ACCESSIBLE ON THE PUBLIC RECORD OF COLLEGES

Although public expectations about access to information are increasing, the *Regulated Health Professions Act (RHPA)* prohibits health regulatory colleges from publicly reporting many of their activities.

The College of Physicians and Surgeons in a letter to the Task Force noted concern that, when one of their members resigns, that information is kept confidential. The college believes that resignations should be a matter of public record. The college has even gone so far as to recommend to HPRAC that all undertakings and agreements with physicians should appear on the college register.

PROVINCIAL, NATIONAL AND INTERNATIONAL DATABASE ACCESS

The College of Occupational Therapists notes in its submission to HPRAC that *RHPA* provisions concerning the sharing of information are limited and, in certain circumstances, conflict with the broader concept of public interest. The college has suggested that it would be beneficial to share information related to complaints and discipline processes with colleagues in other provinces. It has suggested the possibility of a future national database. In order for such a database to work, it is imperative that the database be used.

The College of Nurses has been reviewing models for a national database in the United States. As Dr. Gary Schoener[25] has stated: ***"employers have to be accountable for who they hire."***

Our task force colleague, Dr. Briar Long, who is a third year psychiatric resident, has stated how surprised she was that no prior character check was required of her **before** she was allowed to work alone with young patients.

"I was amazed that I was being asked NOW: not when I applied to medical school; not when I graduated; not when I began working as an intern; not

even when I began my child psychiatry rotation. But, in my third year, I had been seeing children on my own for five months. The policy (of making a character check) had been in place at the clinic for some months, but wasn't being followed."

Dr. Long's words clearly illustrate why a system already in place must be monitored.

In 1991, the Task Force was not surprised, but was disappointed that no national or international database had been created. The Task Force is concerned that the proposed databases are not much further along than they were nine years ago. In our 1991 report, we recommended: *"that physicians be obliged to report to the college, as a condition of license, any criminal convictions related to sexual offences against them, or the initiation of any civil status suits against them that involved alleged sexual impropriety or sexual violation, and that the college check previous licensing bodies of the applicant physicians for such charges prior to granting a license."*[26]

We also recommended, in 1991 that, *"where the college has made a finding of guilt of sexual impropriety or sexual violation, it immediately inform other provincial colleges of physicians and surgeons and other related bodies in Canada and the United States (and) specifically the Board of Action Data Bank kept by the Federation of State Medical Licensing Boards in Fort Worth, Texas, and that a protocol for mutual reporting be developed by the colleges with the Federation of Medical Licensing Authorities of Canada."*

This is a priority initiative for the Public Access Centre (PAC).

PUBLIC INFORMATION AND OUTREACH

Even though section 3 (1) of the *RHPA* stipulates that one of the objects of the colleges is to develop, establish and maintain programs to assist individuals to exercise their rights, the public is still poorly informed.

When the *RHPA* was proclaimed, the Minister of Health indicated that a comprehensive education program to help the public understand the role of the colleges and the public's rights under the new legislation would be developed. We see no evidence that such a program has been put in place.

According to the College of Dental Technologists, most health care consumers are still not aware of the existence of the standards to which health professionals may be held, or of a patient's right to complain. The college also notes that many people are not aware of the fact that colleges are not empowered to provide direct financial remedies to complainants.

The Ministry of Health and Long-Term Care is responsible for ensuring that public education is carried out in a consistent and cost effective way. The College of Dental Technologists believes the lack of a centralised and comprehensive system of public information and education is one of the critical deficiencies in the *RHPA* process.

The College of Pharmacists believes the mandate of college patient relations committees should be expanded to include a public information and education function. The task force believes that doing so would complement the proposed education function of the Public Access Centre (PAC).

We also commend Prince Edward Island's efforts to ensure that the public is made aware of the processes and availability of services for victims of sexual abuse. Section 38.5 of its Act to Amend the Medical Act, 1997 states that: *"the council shall have a continuing program for the purposes of preventing and dealing with sexual abuse including...(b) public awareness education in matters such as warning signals, avoidance tactics, actions to take if abused... and (d) publication of procedures for making sexual abuse complaints and for carrying out investigation and discipline."*

UNREGULATED HEALTH PRACTITIONERS

We are concerned that the public is not made aware of the existence of unregulated health professionals. We believe the public must be told how to protect themselves from potential abuse by such service providers (as well as from regulated health professionals) and that there should be legislation requiring unregulated health service providers to make patients aware they are being treated by someone who is an unregulated health care provider and is not subject to the *Regulated Health Professions Act (RHPA).*

Research is needed to determine the most effective legislative means of protecting the public from unregulated health practitioners who have previously lost their licenses due to sexual abuse of patients or are exploiting their lack of a license as a means of abusing patients.

EDUCATION OF PROFESSIONALS

Section 84 (3) of the *RHPA* specifies that the Patient Relations Committee must have measures for preventing and dealing with sexual abuse and that the measures must include education requirements for members, guidelines for members to follow when dealing with patients, college staff training and the provision of information to the public. Section 84 (4) also states that the council shall give HPRAC a written report that describes the patient relations program and submit a written report concerning changes. These are important monitoring features and should be expedited.

The fact that some health professionals have little direct contact with patients is no guarantee that they will not sexually abuse patients. This was acknowledged in a number of college submissions to HPRAC in 1999. The College of Dieticians says that education and accountability measures regarding the sexual abuse of patients are needed. The College of Pharmacists goes even further, providing education to all members regarding sexual abuse. In fact, education on sexual abuse of patients is a mandatory part of the curriculum at the University of Toronto Faculty of Pharmacy, and all applicants for Ontario registration are tested on their knowledge of the material as part of the jurisprudence examination.

Ontario colleges are not alone in their concern about properly educating health professionals about sexual abuse.

Prince Edward Island legislation makes such education and training mandatory. Section 38.5 of its Act to Amend the Medical Act, 1997 states that: *"the council shall have a continuing program for the purposes of preventing and* *dealing with sexual abuse including; a) obligatory training for all physicians in matters of the law, unacceptable behaviour, warning signals, prevention tactics; (and) b) publication of guidelines for physician contact with patients to prevent abuse."*

If Ontario were to follow Prince Edward Island's model, the (proposed) Public Access Centre (PAC) would be responsible for such training.

A report submitted by the Independent Committee of the College of Physicians and Surgeons of Alberta suggests:

- that changes in medical training be initiated at all levels and include undergraduates, interns, residents, fellows, faculty, practising medical doctors and foreign medical graduates; and
- that the time devoted to sexual abuse education be increased and included in examinations and accreditation throughout training and practise. [27]

The Alberta independent committee report also encourages the college to employ the resources of other professionals, such as survivor advocacy groups, psychologists, social workers and others who have experience with or knowledge of sexual abuse issues in the training of the medical doctors. It also says that curriculum must reflect an understanding of the context in which sexual abuse by medical doctors occurs and provide an understanding of gender socialisation, sex roles, women's equality issues, cultural variables, and the development of health feelings, values and self-awareness about sexuality.

New Brunswick has also implemented legislation to prevent sexual abuse. Section 28.3 (1) of *An Act Respecting Health Professionals* requires that the association undertake measures to prevent the sexual abuse of patients by its members. Section 28.3 (2) further stipulates the measures to be taken, including the education of its members about sexual abuse, guidelines for the conduct of members toward patients, providing information to the public concerning the guidelines, and informing the public of the complaint procedures available under the act.

CONCLUSION

During our public and private hearings, patients kept stressing how their lack of access to information undermined every aspect of their attempts to obtain appropriate responses to their complaints. The new model for self-regulation introduced in Chapter 2 of this report (the Public Access Centre) is designed to respond to patients' needs and suggestions for improvements, based on their well-documented frustrations. This significant change in the way that colleges and the ministry serve the public interest must have the foundation of legislative commitments and strong policies to open up the processes to patients and the public.

RECOMMENDATIONS - CHAPTER SEVEN

In closing, we offer nine final recommendations to complete our Advice and Recommendations on strategies to stop sexual abuse of Ontario patients. We are mindful that Ontario has been recognised as an international leader in this field and that our proposals have been designed to shift resources to a more co-operative and efficient patient-centred model of self-regulation.

INFORMATION ACCESSIBLE ON THE PUBLIC RECORD OF COLLEGES

RECOMMENDATION 26.0

26.0 Section 23(3)3.1 of the *RHPA Code* should be amended to require that every College Register includes disciplinary decisions in which the member was found to have committed an act of sexual abuse as defined in section 1(3)(c) [behaviour and gestures] as well as 1(3) (a) [physical sexual relations] and (b) [touching of a sexual nature] of the Code and that staff of colleges are clearly obliged to inform anyone who inquires as to the nature of the complaint.

RECOMMENDATION 27.0

27.0 Section 23(2) of the *RHPA Code* should be amended to ensure that College Registers contain any stipulations or programs imposed on a member related to any complaint of sexual abuse of a patient, with a notation on whether the requirements were met.

RECOMMENDATION 28.0

28.0 The *RHPA* should be amended to require each college to publish and maintain on the public record all disciplinary panel decisions, or determinations through any other means, including suspension or resignation of the member, related to sexual abuse complaints processed by that college.

RECOMMENDATION 29.0

29.0 Applications for a certificate of registration or for reinstatement of a certificate to any college under the *RHPA* are to require verification as to good character, including sworn statements as to: previous convictions or charges of a criminal nature, any civil findings where the member has been a party in a lawsuit involving sexual abuse or harassment, and reasons given for resignation or suspension if the member has resigned or was suspended from a college or any other health profession in any other jurisdiction.

29.1 Applications for reinstatement must include reference to any conditions placed by the college, which the health professional was to meet, and evidence that the conditions have been met, prior to making the application.

PROVINCIAL, NATIONAL AND INTERNATIONAL DATABASE ACCESS

RECOMMENDATION 30.0

30.0 The *RHPA* should be amended to ensure that, once a finding of guilt in a sexual abuse complaint is made in a discipline hearing or determination of any kind, including resignation, colleges are legally obliged to inform all other licensing authorities in Canada and to keep written records verifying notification.

Recommendation 31.0

31.0 The Ministry of Health and Long-Term Care should initiate joint and reciprocal ventures to establish and maintain both a national and international database of sexual abuse offenders who are regulated health care professionals to inform and be informed by health professional licensing authorities and health care institutions in other jurisdictions.

Protection from Sexual Abuse by Unregulated Health Practitioners

Recommendation 32.0

32.0 The Ministry of Health and Long-Term Care and the HPRAC Monitoring Team, in consultation with the Public Access Centre and the colleges, should commission research to determine the most effective legislative means for creating and maintaining a public record listing unregulated health practitioners who have previously lost their licences due to sexual abuse of patients.

Education of Health Professionals

Recommendation 33.0

33.0 HPRAC should ensure that its current review of all the Patients Relations Programs of the colleges includes analysis of confidential evaluations, by first year graduates in each regulated health profession and by patients and patients' advocacy groups, of the following measures required under section 84 of the *RHPA Code*:

a) educational requirements;

b) guidelines members are to follow when dealing with patients; and

d) provision of information to the public.

Recommendation 34.0

34.0 The Ministry of Health and Long-Term Care, in co-operation with the Public Access Centre, health regulatory colleges, post secondary institutions and patients' advocacy groups, should immediately initiate the following changes:

a) creation of mandatory course materials that include the perspectives of patients, on preventing sexual abuse of patients, for every level of professional training and continuing education applicable to regulated health professions in Ontario,

b) require that colleges ensure that all applicants for registration in Ontario are tested on their knowledge of the dynamics of sexual abuse of patients and their responsibilities as regulated health professionals,

c) require that the Public Access Centre, in co-operation with the colleges and patients' advocacy groups, prepare, publish, disseminate and update guidelines for the public and health professionals to prevent sexual abuse of patients.

Endnotes

CHAPTER 1 – LISTENING TO PATIENTS

1 Judith Herman, M.D., *Trauma and Recovery* (Basic Books, 1997) at page 7.

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5 Fassel, Mary Lou, Director, Legal Services for the Barbara Schlifer Commemorative Clinic , Letter to the Task Force dated July 17 2000.

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9 PricewaterhouseCoopers (PwC) Evaluation for HPRAC, Volumes 18, 22, July, 1999.

10 Berger, Earl. Hay Health Care Consulting Group, The Berger Population Health Monitor.

CHAPTER 3 - SELF REGULATION IN THE PUBLIC INTEREST

11 College of Psychologists, submission to HPRAC, December,1999 at p.18; College of Massage Therapists, at p.12; College of Occupational Therapists, at p. 29; College of Medical Radiation Technologists, at p.15; College of Physiotherapists, at p. 12; College of Dental Technologists, at p.10.

12 (1998) O.J. No., 5222 Ontario Divisional Court Rosenberg, J.

13 Steinecke, R.A. *A Complete Guide to the Regulated Health Professions Act*. Canada Law Book: Aurora Ontario, Looseleaf Service, updated January 2000. 10-4, 4-12

14 Robins, The Honourable Sydney. *Protecting our Students: A Review to Identify and Prevent Sexual Misconduct in Ontario Schools*, (February, 2000, Ontario Ministry of the Attorney General)

15 Rodgers, *supra* p.188

CHAPTER 4 – IMPACT OF COLLEGE PROCESSES ON PATIENTS

16 Statements at Public Hearing of Special Task Force by Susan M. Vella, Counsel to the Grandview Survivors Support Group, Goodman and Carr, Barristers and Solicitors, Toronto, and co-author with Elizabeth K.P. Grace of *Civil Liability for Sexual Abuse and Violence in Canada* (Butterworths: Toronto, 2000)

CHAPTER 5 – DETERRENTS AND PENALTIES

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20 Garfinkel P, Dorian B, Sadavoy J, et al: "Boundary Violations and Departments of Psychiatry." Can J. Psychiatry 42.764-770, 1997.

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CHAPTER 6 – MEDIATION, SUPPORT AND THERAPY FOR PATIENTS

22 Steinecke, R., supra Page 6-97

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24 Fassel ML. *supra* note 5

CHAPTER 7 – INFORMATION, EDUCATION AND TRAINING

25 Schoener, G. quoted in the Toronto Star "Doctors' watchdog like 'secret service'" June 12, 1999

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Afterword

The Dialectic of Trauma Continues, Judith Herman, M.D.

Members of the Special Task Force are indebted to Dr. Judith Herman and Basic Books, a member of Perseus Books Group, for permission to reprint this Afterword of Dr. Herman's book, "*Trauma and Recovery*" in our final report to the government and to the people of Ontario. This report will not be sold for profit.

AFTERWORD

The Dialectic of Trauma Continues

IN WRITING *Trauma and Recovery,* it was my ambition to integrate the accumulated wisdom of the many clinicians, researchers, and political activists who had borne witness to the psychological effects of violence and to set forth in one comprehensive treatise a body of knowledge that had been periodically forgotten and rediscovered over the past century. I argued then that the study of psychological trauma is an inherently political enterprise because it calls attention to the experience of oppressed people. I predicted that our field would continue to be beset by controversy, no matter how solid its empirical foundation, because the same historical forces that in the past have consigned major discoveries to oblivion continue to operate in the world. I argued, finally, that only an ongoing connection with a global political movement for human rights could ultimately sustain our ability to speak about unspeakable things.

In the five years since the book's publication, new victims of violence have numbered in the millions. The massive communal atrocities committed during the course of wars in Europe, Asia, and Africa have focused international attention on the devastating impact of violence and have fostered the recognition that psychological trauma is indeed a worldwide phenomenon.[1] At the same time, as observance of distinctions between civilians and combatants in war has widely broken down, the political nature of violence against women and children has become more apparent. The flagrant, systematic use of rape as a tool of warfare in many parts of the world has created a horrible occasion for consciousness-raising.[2] As a result, rape has now been recognized internationally as a violation of human rights, and crimes against women and children have been accorded (at least in theory) the same gravity as other war crimes.[3]

Within the U.S., a number of large-scale community studies have demonstrated that, even in peacetime, exposure to violence is both more commonplace and more damaging than anyone would like to believe.[4] The enduring consequences of our endemic social violence have only begun to be appreciated.[5] For example, one research team has undertaken an ambitious long-term study, following the fate of a group of girls who suffered documented sexual abuse as they grow into adolescence and adulthood. This study, now in its tenth year, is demonstrating the profound developmental impact of childhood trauma with a degree of rigor previously unattainable.[6] These studies lend further weight to the massive body of evidence documenting the cost of violence.

As predicted, the study of psychological trauma has remained highly controversial. Many clinicians, researchers and political advocates who work with traumatized people have come under fierce attack. In spite of this onslaught, however, thus far the field has vigorously resisted being "disappeared." On the contrary, during the past five years, the scientific enterprise of traumatic stress studies has expanded and matured. The fundamental question of the existence of PTSD is no longer in dispute.[7] With the basic outlines of the field defined, an early pioneering era has ended, and research has become both more technically sophisticated and in some respects more ordinary. A new generation of studies has begun to enlarge the scope and increase the precision of our understanding of the impact of traumatic events.

Some of the most exciting recent advances in the field derive from highly technical laboratory studies of the biologic aspects of PTSD. It has become clear that traumatic exposure can produce lasting alterations in the endocrine, autononomic, and central nervous systems.[8] New lines of investigation are delineating complex changes in the regulation of stress hormones,[9] and in the function and even the structure of specific areas of the brain. Abnormalities have been found particularly in the amygdala and the hippocampus, brain structures that create a link between fear and memory.[10]

Biological, clinical, and social investigations have continued to converge on the fascinating phenomenon of dissociation. It has become clear that, as Janet observed one hundred years ago, dissociation lies at the heart of the traumatic stress disorders. Studies of survivors of disasters, terrorist attacks, and combat have demonstrated that people who enter a dissociative state at the time of the traumatic event are among those most likely to develop long-lasting PTSD.[11] Previously, many clinicians, myself included, viewed the capacity to disconnect mind from body as a merciful protection, even as a creative and adaptive psychological defense against overwhelming terror. It appears now that this rather benign view of dissociation must be reconsidered. Though dissociation offers a means of mental escape at the moment when no other escape is possible, it may be that this respite from terror is purchased at far too high a price.

Further evidence for the pathogenic role of dissociation has come from a large-scale clinical and community study of traumatized people conducted by a task force of the American Psychiatric Association. In this study, people who reported having dissociative symptoms were also quite likely to develop persistent somatic symptoms for which no physical cause could be found. They also frequently engaged in self-destructive attacks on their own bodies.[12] The results of these investigations validate the century-old insight that traumatized people relive in their bodies the moments of terror that they can not describe in words. Dissociation appears to be the mechanism by which intense sensory and emotional experiences are disconnected from the social domain of language and memory, the internal mechanism by which terrorized people are silenced.[13]

Laboratory studies have now begun to unravel the neurobiology of dissociation. For example, one elegant experiment has demonstrated that a similar mental state can be produced pharmacologically in normal human subjects. This was done by administering ketamine, a drug that antagonizes the action of the neurotransmitter glutamate in the central nervous system. Unlike traumatized people, subjects who received ketamine did not report any subjective experience of fear. However, they did experience characteristic dissociative alterations in attention, perception and memory, including insensitivity to pain, time slowing, depersonalization, derealization, and amnesia.[14] Ketamine is thought to work by inhibiting the activity of large neurons in the cerebral cortex. These neurons form a complex network of *associative* pathways, linking areas of the brain involved in memory, language, abstract thought, and social communication. Temporary inactivation of these pathways experimentally reproduces a dissociative state.

Thus *dissociation,* a descriptive term derived entirely from clinical observation, may turn out to be an accurate term for a neurobiological phenomenon as well. Future investigations are required to determine whether terror operates by a similar mechanism to inactivate cortical associative pathways in the brain. Preliminary results of brain scanning studies of patients with PTSD, using the sophisticated technique of positron emission tomography, suggest that during flashbacks, specific areas of the brain involved with language and communication may indeed be inactivated.[15]

As evidence of the central importance of dissociation in traumatic stress disorders has continued to accumulate, it has also become apparent that dissociation offers a window into consciousness, memory, and the links between body and mind. Posttraumatic and dissociative phenomena have therefore begun to attract the attention of a new generation of basic researchers, whose interest does not stem primarily from engagement with traumatized people, but rather from a more abstract scientific curiosity. This development constitutes a welcome sign that traumatic stress studies are moving into a status of full legitimacy within the mainstream of scientific investigations.

Legitimacy, however, can be a mixed blessing. The next generation of researchers may lack the passionate intellectual and social commitment that inspired many of the most creative earlier investigations. In this new, more conventional phase of scientific inquiry, there is some cause for concern that integrative concepts and contextual understanding of psychological trauma may be lost, even as more precice and specific knowledge is gained. The very strength of the recent biological findings in PTSD may foster a narrowed, predominantly biological focus of research. As the field of traumatic stress studies matures, a new generation of researchers will need to rediscover the essential interconnection of biological, psychological, social, and political dimensions of trauma.

Particular care must be taken also to avoid the reenactment of a pattern of exploitative relationships within the research enterprise itself. Survivors of terrible events are often motivated to volunteer as research subjects in the hope that helping others may give meaning and dignity to their suffering. The relationship between survivor and investigator is subject to the same power imbalances and the same contagious emotions as any other relationship. Early investigators often felt strong personal bonds and political solidarity with trauma survivors, regarding them less as objects of dispassionate curiosity than as collaborators in a shared cause. This kind of closeness and mutuality may be difficult to sustain in a scientific culture where unbiased observation is often thought to require a distant and impersonal stance. Yet without it, the possibility of authentic understanding is inevitably lost.

The collaborative working relationship with the trauma survivor also remains the cornerstone of treatment of PTSD. The principle of restoring human connection and agency remains central to the recovery process and no technical therapeutic advance is likely to replace it. At the same time, as evidence of the lasting biological alterations of PTSD has mounted, the search for a specific treatment that might mitigate these effects has also intensified. In the past five years, innovative treatment techniques have proliferated and a period of active competition for acceptance has begun. Comparison of new treatment methods developed independently by individual creative pioneers may yield some insight into their underlying common principles.[16] Consensus on the most effective approaches to treatment of PTSD awaits the results of many more carefully controlled studies of treatment outcome. A number of such studies are now in development or already underway, and should come to fruition in the next few years.

Insight into the recovery process may also be gained by drawing upon the wisdom of the majority of trauma survivors worldwide, who never get formal treatment of any kind. To the extent that they recover, most survivors must invent their own methods, drawing on their individual strengths and the supportive relationships naturally available to them in their own communities. Systematic studies of resilience in untreated survivors hold great promise for developing more effective and widely adaptable methods of therapeutic intervention.[17] The search for simple and reproducible models of intervention has now become an international, cross-cultural project, as part of a growing effort to mount an international response to outbreaks of war and mass violence.

Stages of recovery can be observed not only in the healing of individuals but also in the healing of traumatized communities. International diplomatic, military and humanitarian efforts have been organized in an attempt to reestablish basic safety in many countries devastated by warfare. On this scale, safety requires putting an immediate stop to the violence, containment if not disarmament of the aggressors, and provision for the basic survival needs of the victims. All of the classic political conflicts between victims, perpetrators, and bystanders have been reenacted in these most recent peacemaking and peacekeeping efforts. Once again, victims have been outraged by the apparent indifference and passivity of bystanders. Once again, perpetrators of atrocities have gloated before the world. The many appalling inadequacies of international interventions in Africa and Southern Europe hardly bear repetition. Nevertheless, the organization of peacemaking on a scale that transcends the ordinary diplomatic goals and military interests of individual nation-states represents an important advance.

In many countries that have recently emerged from dictatorship or civil war, it has become apparent that putting an immediate stop to the violence and attending to basic survival needs of the affected populations are necessary but not sufficient conditions for social healing. In the aftermath of systematic political violence, entire communities can display symptoms of PTSD, trapped in alternating cycles of numbing and intrusion, silence and reenactment. Recovery requires remembrance and mourning. It has become clear from the experience of newly democratic countries in Latin America, Eastern Europe, and Africa, that restoring a sense of social community requires a public forum where victims can speak their truth and their suffering can be formally acknowledged. In addition, establishing any lasting peace requires an organized effort to hold individual perpetrators accountable for their crimes. At the very least, those responsible for the worst atrocities must be brought before the law. If there is no hope of justice, the helpless rage of victimized groups can fester, impervious to the passage of time. Demagogic political leaders well understand the power of this rage, and are only too willing to exploit it by offering to an aggrieved people the promise of collective revenge. Like traumatized individuals, traumatized countries need to remember, grieve, and atone for their wrongs in order to avoid reliving them.[18]

In the aftermath of dictatorship and war, dialectic of trauma is often played out as a ferocious battle over the question of impunity. Perpetrators of massive political crimes may still hold considerable residual power, even after their worst depredations have been curtailed, and they have no interest in public truth-telling. On the contrary, they remain implacably committed to secrecy, and fiercely opposed to any effort to establish a reckoning of their abuses. Faced with the prospect of accountability, perpetrators often become extremely aggressive. To resist being brought to justice, they will marshal the same methods of intimidation and deceit that they once used to dominate their victims. When newly elected governments in Southern Europe, Latin America, Central America, and South Africa have attempted to uncover the political crimes of the recent past, they have met with violent retaliation. Perpetrators will do anything in their power to preserve the principle of impunity. They demand amnesty, a political form of amnesia.

Under the threat of renewed violence, one country after another has played out the conflict between knowing and not knowing, speech and silence, remembering and forgetting. In the interest of maintaining a hard-won peace, fragile democracies have often submitted to the demand for amnesty, even while trying to avoid succumbing to complete amnesia. In Latin America, many countries have permitted an official record of human rights violations to be established, but have recoiled from the attempt to bring perpetrators to justice. In the former Yugoslavia, the international community has supported the establishment of a War Crimes Tribunal, but has been unwilling to arrest and bring to trial indicted war criminals. In South Africa, the officially established Truth and Reconciliation Commission has offered perpetrators a limited time period in which amnesty will be granted in return for public confession. Implicit in this bargain is the belief that if full justice cannot be achieved, public acknowledgment of the truth is more important than punishment of the perpetrators. The principle of legal accountability has not been entirely compromised, however, since the government has made clear its determination to prosecute political criminals who do not voluntarily confess. The outcome of this most recent experiment in social healing has yet to be determined.

In still other parts of the world, newly established democracies have had to contend with a past record of abuses that were endemic to the entire political system. In these societies (for example, in Eastern Europe), dictatorship demanded not merely the acquiescence but the complicity of the general population. As a result, a great number of people violated the trust of their neighbors, friends, and relatives. These societies are now faced with the problem of establishing accountability for abuses that were pervasive and officially condoned at the time that they were committed. Holding all collaborators criminally responsible is simply not feasable, even if it were desirable. Yet without some form of public acknowledgement and restitution, all social relationships remain contaminated by the corrupt dynamics of denial and secrecy.

Our own society faces a similar dilemma with respect to the legacy of slavery. The unhealed racial divisions of our country create an ongoing potential for violence. The worst civil disturbance of the past few years, the Los Angeles riots, were provoked by the failure of the justice system to hold armed white police officers accountable for the severe beating of an unarmed black man. Within the African-American community, it was widely understood that such abuses were political crimes, carried out as part of a systematic pattern of racial oppression. The issue at trial was whether the larger society would condone the most flagrant of these human rights abuses. The responsibility to bear witness fell to the jury in the criminal trial. In their refusal to see the crime that was documented before their eyes, we can recognize the familiar defenses of denial, distancing, and dissociation. As is so often the case, the bystanders chose to identify with the perpetrators rather than with the victim, and it was this betrayal, not simply the violence of the police, that unleashed a communal outbreak of murderous rage. In the words of one community activist:

> you know, with No Justice, No Peace . . .
> I guess you might say it's fairly simple,
> but to me it's pretty, um
> not complex,
> but then again it's deep,
> it's nothin' shallow.
> It basically means if there' s no justice here
> then we not gonna give them any peace.
> You know, we don't have any peace
> They not gonna have no peace.[9]

The problem of coming to terms with endemic abuses of power also pertains to crimes of sexual and domestic violence. Because subordination of women and children has been so deeply embedded in our culture, the use of force against women and children has only recently been recognized as a violation of basic human rights. Widespread patterns of coercive control such as battering, stalking, sexual harassment, and acquaintance rape were not even named, let alone understood to be crimes, until they were defined by the feminist movement. Even the forms of violence that were nominally criminalized, such as sexual abuse of children, have been so rarely reported or prosecuted in the past that perpetrators were effectively guaranteed impunity.

In the past two decades, however, legal reforms inspired by the feminist movement have opened the door a little bit wider for victims of sexual and domestic crimes to seek justice in court, and strong grassroots support services have encouraged more victims to confront their abusers. As a result, although the great majority of victims still avoid making any official complaint, perpetrators can no longer be entirely confident of escaping justice. In a number of highly publicized trials, prominent and powerful men (priests, politicians, star athletes) have been compelled to answer for crimes that they clearly felt entitled to commit against women or children. These trials have served as a kind of political theater, in which tragedy is reenacted, and the complex moral issues of accountability are debated.

Faced with the possibility of a public reckoning, accused perpetrators have organized to mount a renewed assault on the credibility of victims. Child advocates, psychotherapists, and others who bear witness and lend support to victims have also been subject to aggressive and organized attack.[20] The conflict has been particularly bitter concerning sexual abuse of children. Because children are the most powerless of victims, often dependent upon their abusers, their chances for justice have ever been the most remote. In addition, children subjected to prolonged, repeated abuse are particularly prone to develop memory disturbances that further compromise their ability to tell their stories.[21] Many states have sought to remedy this injustice by extending the statute of limitations for sexual assaults against children. Adult survivors who belatedly recall their abuse after a period of amnesia have been granted the opportunity to testify and seek redress in court. This reform has significantly expanded the potential reach of the law.

In response, advocates of accused perpetrators have argued that complaints based on delayed recall should be dismissed out of hand, because recovered memories can not possibly be true. They have maintained, rather, that such memories must be wholesale fabrications, invented by psychotherapists, and implanted in gullible minds by means of coercive persuasion. Survivors who come forward to reveal their childhood recollections have been portrayed as the pawns of a malignant cabal of psychotherapists with extraordinary suggestive powers.[22]

When these arguments were first proposed several years ago, I found them almost ludicrously implausible, and thought that their frank appeal to prejudice would be transparent at once. The women' s movement had just spent twenty years deconstructing the presumption that women and children are prone to lie, fantasize, or fabricate stories of sexual violation. If any principle had been established, surely it was that victims are competent to testify to their own experience. Yet once again, here were eminent authorities proclaiming that victims are too weak and foolish to know their own minds. Hadn't we just gone through all this? Did we really need to go through it again?

Apparently the answer was yes. The notion of a contagion of false complaints struck a responsive chord in the public media and some quarters of academia. The cry of "witch hunt" was raised, evoking the image of packs of irrational and vengeful women bent on indiscriminate slander. The "recovery movement" of survivors of childhood abuse and their therapist allies seemed to evoke particularly intense hostility and scorn.[23] The press seemed to be tired of hearing about victims and eager to take the side of those who insisted that they had been wrongly accused.[24]

Challenges to the credibility of victims and therapists also enjoyed some success in the courtroom.[25] In a number of disturbing cases, adult women were denied the opportunity to give their testimony because of the concern that their minds might have been contaminated by psychotherapy.[26] In one closely watched case, a father accused of incest by his daughter successfully sued for damages, in spite of the fact that the jury was unable to decide whether the accusations were true or false. The accusing daughter was not held responsible for harming her father. Rather, the jury found the daughter's *therapists* liable for encouraging her belief that she had been abused and helping her to retrieve her memories. The young woman, testifying in defense of her therapists, protested that she alone was responsible for her memories. "My father doesn't seem to get the point," she stated on the witness stand, "I'm the one telling him he abused me."[27] The jury disregarded her testimony. Once again, a victim became invisible.

This trial put psychotherapists on notice that listening to survivors can carry certain risks and dangers. Underlying the attack on psychotherapy, I believe, is a recognition of the potential power of any relationship of witnessing. The consulting room is a privileged space dedicated to memory. Within that space, survivors gain the freedom to know and tell their stories. Even the most private and confidential disclosure of past abuses increases the likelihood of eventual public disclosure. And public disclosure is something that perpetrators are determined to prevent. As in the case of more overtly political crimes, perpetrators will fight tenaciously to ensure that their abuses remain unseen, unacknowledged, and consigned to oblivion.

The dialectic of trauma is playing itself out once again.[28] It is worth remembering that this is not the first time in history that those who have listened closely to trauma survivors have been subject to challenge. Nor will it be the last. In the past few years, many clinicians have had to learn to deal with the same tactics of harassment and intimidation that grassroots advocates for women, children and other oppressed groups have long endured. We, the bystanders, have had to look within ourselves to find some small portion of the courage that victims of violence must muster every day.

Some attacks have been downright silly; many have been quite ugly.

Though frightening, these attacks are an implicit tribute to the power of the healing relationship. They remind us that creating a protected space where survivors can speak their truth is an act of liberation. They remind us that bearing witness, even within the confines of that sanctuary, is an act of solidarity. They remind us also that moral neutrality in the conflict between victim and perpetrator is not an option. Like all other bystanders, therapists are sometimes forced to take sides. Those who stand with the victim will inevitably have to face the perpetrator's unmasked fury. For many of us, there can be no greater honor.

Judith Lewis Herman, M.D.
February, 1997

Appendix I

Excerpts from:

- Health Minister's letter January 2000
- HPRAC letter March 2000
- Ministry of Health letter June 2000

**Ministry
of
Health**

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel (416) 327-4300
Fax (416) 326-1571

**Ministère
de
la Santé**

Bureau du ministre

10e étage, édifice Hepburn
80 rue Grosvenor
Toronto ON M7A 2C4
Tél (416) 327-4300
Téléc (416) 326-1571

Ontario

JAN 0 7 2000

Robert Alder, PhD
Chair, Health Professions Regulatory Advisory Council
2195 Yonge Street
4th floor
Toronto, ON M4S 2B2

Dear Dr. Alder:

Re: Referral regarding HPRAC's Five Year Review on the Effectiveness of each College's Complaints and Discipline Procedures relating to Sexual Abuse

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This is a referral to the Health Professions Regulatory Advisory Council (HPRAC) in accordance with section 12 of the *Regulated Health Professions Act, 1991* (RHPA). The referral relates to HPRAC's five year report of the effectiveness of each College's complaints and disciplines procedures relating to professional misconduct of a sexual nature, pursuant to section 6(2) under the RHPA.

It is imperative that HPRAC's report thoroughly evaluate each College's complaints and discipline procedures relating to sexual abuse, including the impact of such procedures on the complainants themselves.

To assist HPRAC in its report, Ms. Marilou McPhedran and three colleagues will form a Special Task Force for the purpose of providing a submission comprising *Advice and Recommendations* to HPRAC. Ms. McPhedran will serve as Chair of the Special Task Force. With the administrative support of HPRAC, the Special Task Force will hold one day of public hearings. One day of *in camera* hearings may also be held if, in the opinion of the Special Task Force, they are needed. The hearings are to be held in Toronto, Ontario in early May, 2000. The Special Task Force may also accept written submissions from the public. These should be sent to HPRAC's mailing address and forwarded to the Chair and members of the Special Task Force.

It is anticipated that the Special Task Force may decide to use newspaper advertisements to alert the public to the submissions and hearings process. HPRAC should provide support for the publication of an ad, to run for one day only, in *The Toronto Star* and the Ontario edition of *The Globe and Mail*.

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The Special Task Force shall provide its submission to HPRAC within 30 days of holding the hearings. One copy of the Special Task Force's *Advice and Recommendations* submission shall be submitted to HPRAC and a summary opinion letter respecting the submission will be provided to the Minister. The Special Task Force's *Advice and Recommendations* must be considered by HPRAC, along with all other submissions and evidence before it, and included in HPRAC's final report. The Special Task Force submission will be considered confidential by HPRAC and the Special Task Force until HPRAC's final report has been submitted to the Minister of Health and Long-Term Care.

The following questions should form part of the Special Task Force's inquiry during the hearings. However, please note that they are not in any way intended to be exhaustive of the issues that may be dealt with at the hearings:

1. How do the Colleges' complaints and disciplines processes impact on individuals who complain of being sexually abused by members?
2. What penalties have been applied when a member claims that the sexual relations between the member and the client/patient are consensual?
3. Are the mandatory revocation penalty provisions effective or should the mandatory provisions be amended?
4. Do individuals who have been sexually abused by members feel that the penalties imposed by College Committees and the Courts are fair and just?
5. Under what circumstances is mediation being used by Colleges in the complaints and disciplines processes related to sexual abuse? Are complainants satisfied with the mediation process?

HPRAC shall provide remuneration to the Special Task Force. The Chair of the Special Task Force is to receive remuneration at the same daily rate as a Chair of a Board under the *Ministry of Health Appeal and Review Boards Act, 1998*, and members of the Special Task Force are to receive remuneration at the same daily rate as members of the Boards under that Act.

Your assistance to the Special Task Force in providing their *Advice and Recommendations* submission and your ongoing work with the five year review is greatly appreciated. I look forward to receiving your advice.

Yours truly,

Elizabeth Witmer, MPP
Minister

Health Professions
Regulatory Advisory
Council

2195 Yonge Street, 4th floor
Toronto ON M4S 2B2
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TDD (416) 327-0823
Web site www.hprac.org
E-mail info@hprac.org

Conseil consultatif sur
la réglementation
des professions de la santé

2195, rue Yonge, 4ᵉ étage
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Téléc (416) 326-1549
ATS (416) 327-0823
Site web www.hprac.org
Courriel info@hprac.org

Ontario

March 16, 2000

Ms. Marilou McPhedran
Special Task Force
415 Yonge St. Suite 1800
Toronto ON M5B 2E7

Dear Marilou,

With respect to the public hearings, the Minister's letter of referral states five questions that should form part of the Special Task Force's inquiry and indicates that additional issues may be dealt with at the hearings. We would like to propose the following additional questions for inclusion in your inquiry:

1. How can the public be better informed about (a) where to file a complaint about professional misconduct of a sexual nature by a regulated health professional and (b) Colleges' complaints and discipline procedures?
2. What would be the most appropriate status for the complainant throughout the complaints and discipline processes?
3. How can the complaints and discipline processes for professional misconduct of a sexual nature be made more sensitive and respectful towards complainants?
4. What is the experience of complainants in accessing funding for therapy or counselling from Colleges?
5. Should regulated health professionals be required to disclose the name of the affected patient/client in a mandatory report?

Should you require clarification on the process for flow of funds to the Task Force or on the proposed questions, please feel free to contact Sheila Mawji at (416) 326-3456.

Sincerely,

Rob Alder, MMedSc, PhD
Chair

Encl

**Ministry
of
Health**

**Ministère
de
la Santé**

Ontario

Program Policy Branch
8th Floor Hepburn Block
80 Grosvenor Street
Toronto ON M7A 1R3
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Direction des politiques relatives aux programmes
8e étage, édifice Hepburn
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Toronto ON M7A 1R3
Fax/Télécopieur: (416) 327-8879

June 20, 2000

Ms. Marilou McPhedran
Chair
Special Task on Sexual Abuse
415 Yonge Street
Suite 1800
Toronto ON M5B 2E7

Dear Marilou:

This is confirmation of the issues discussed at our meeting of May 26, 2000.

In addition, I would like to reiterate the Ministry's direction that the Special Task Force focus on its mandate which is *"to hold public and private hearings and receive submissions from members of the public in order to provide advice and recommendations to the Minister on the the public's experience with colleges' complaints and discipline process in cases of a sexual nature."* These hearings have been held, a public hearing on May 24th and a private hearing on May 31st.

In light of this, and in order to avoid duplication Task Force members or individuals working for the Task Force are requested not to contact the regulatory colleges further. The Regulatory Colleges have already done extensive work with HPRAC and their consultants in conducting a review of these processes and providing the required information to HPRAC.

The work of your Task Force will provide an important contribution to HPRAC's overall review of the complaints and discipline process of the regulatory colleges with respect to cases of sexual abuse. The Special Task Force should provide HPRAC with advice and recommendations based on your findings from the public and private hearings and identify any additional work that may be required.

... 2

We appreciate the ongoing interest that you and other members of the Task Force have shown in contributing to this important issue and look forward to further discussion with you about your finding and recommendations.

Sincerely,

Mary Beth Valentine

Mary Beth Valentine
Director

The Ministry of Health has changed its name to the Ministry of Health and Long-Term Care. To avoid extra costs, we are using our existing letterhead paper before printing a supply with the new name.

Le ministère de la Santé a changé de nom: Ministère de la Santé et des Soins de longue durée. Afin d'éviter des coûts supplémentaires, nous utilisons le stock de papier en-tête en réserve avant d'imprimer une provision portant le nouveau nom.

Appendix II

Media Notices of Public and Private Hearings

MEDIA NOTICES REGARDING THE HEARINGS

Community Newspapers Outside Toronto May 12 – 16, 2000

-10-Tuesday, May 16, 2000 - **The Amherstburg Echo**

We Want To Hear From Patients On May 24th In Toronto.

The Special Task Force on Sexual Abuse of Patients by Regulated Health Professionals is conducting an independent inquiry into the experiences of patients and members of the public in order to provide Advice and Recommendations to the Health Professions Regulatory Advisory Council and the Ontario Minister of Health, as part of the five year review of The Regulated Health Professions Act in Ontario.

We are very concerned about the processes experienced by patients in Ontario who have complained about sexual abuse, and we welcome your information if you have had any experience of this kind.

- If you wish to make a submission to the public hearing of the Task Force on May 24th, 2000, we need to hear from you immediately.
- Some private hearing times are available on May 31st. Please contact Karen Brown, 1-877-380-0490, to arrange a time.
- In addition to the Hearings, submissions from patients, members of the Health Professions and the public are all welcome, in writing or as messages on our 24 hr. toll free line 1-877-380-0490.
- Confidential submissions need to be received by the Task Force by May 24th, 2000 in order to be considered for our Report.
- Please mail submissions to:
  Special Task Force
  Suite 1800, 415 Yonge Street,
  Toronto, Ontario, M5B 2E7
- Please fax submissions to: 1- 416 - 595 - 7191
- Web site : http://www.yorku.ca/sexabuse
- Email: sxabtf@web.net

Members of the Special Task Force are: Marilou McPhedran (Chair), Harvey Armstrong, Briar Long, Pat Marshall, and Roz Roach.

This notice was placed in the Amerstburg Echo, as well as in thirteen other community newspapers in different regions of Ontario, as follows:

The Advance, Barrie;
The Kourier, Kanata;
The Independent Plus, Listowel;
The Pen Free Press, Midland;
The Kingston This Week, Kingston;
The Napanee Saturday Beaver, Napanee;
The Nepean This Week, Nepean;
The Orleans Weekly Journal East, Orleans;
The News South, Ottawa;
The Smith Falls Record News, Smith Falls;
The Sudbury Northern Life; Sudbury;
The Post, Thunder Bay; and
The Waterloo Chronicle, Waterloo

MEDIA NOTICES REGARDING THE HEARINGS
The Toronto Star, April 7, 2000

THE TORONTO STAR Friday, April 7, 2000 A21

Advertisement

The Special Task Force on Sexual Abuse of Patients

by Regulated Health Professionals is conducting an independent inquiry into the experiences of patients and members of the public in order to provide Advice and Recommendations to the Health Professions Regulatory Advisory Council and the Ontario Minister of Health, as part of the five year review of The Regulated Health Professions Act in Ontario.

If you wish to make a submission to the Public Hearing of the Task Force on May 24, 2000, we need to hear from you by April 30th. Some Private Hearing times are available on May 31. Presentations to the Hearings will be by invitation of the Task Force. In addition to the Hearings, submissions from patients, members of the public, advocacy groups and regulated health professionals are welcome, in writing or on our toll-free line: 1-877-380-0490, to be received by May 15, 2000, in order to be considered in our Report.

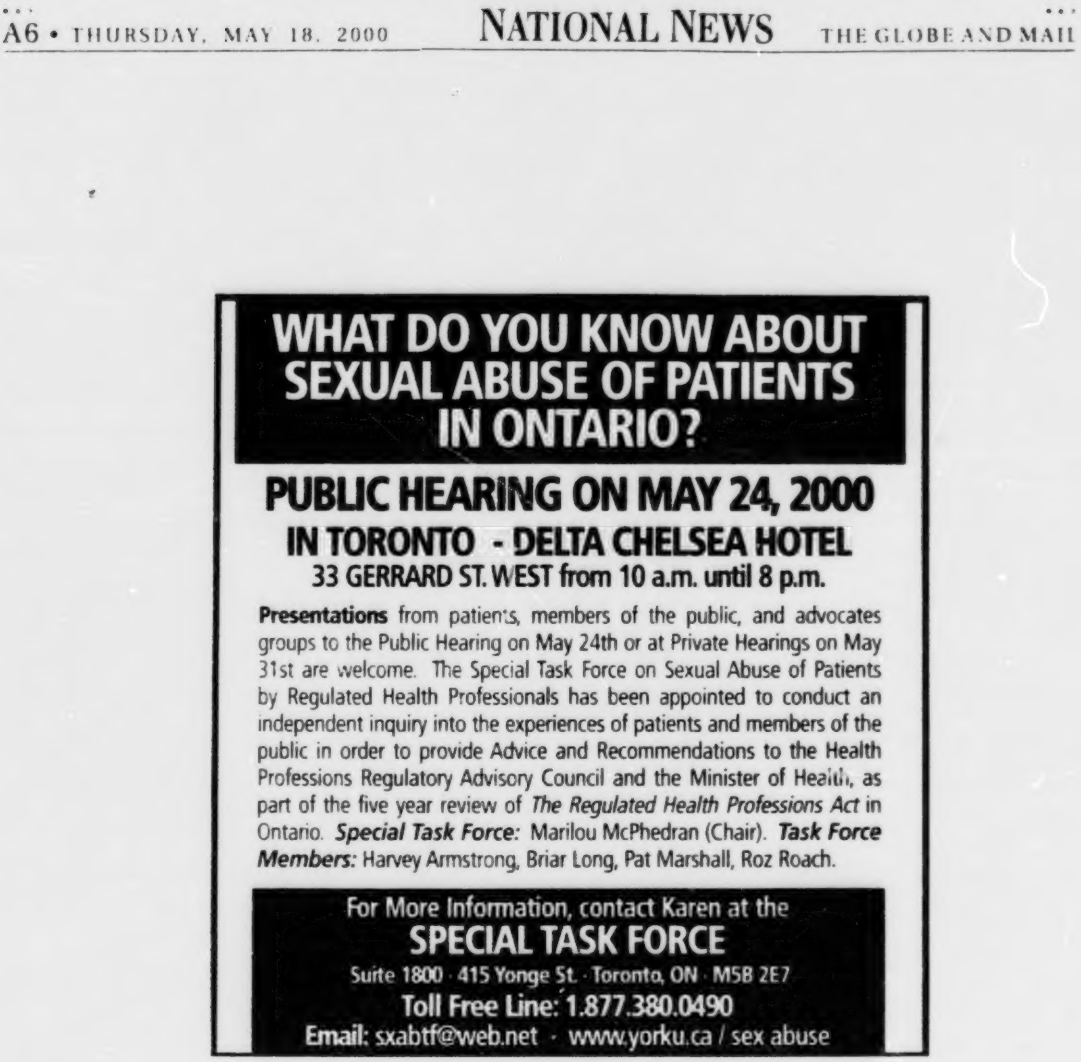
Special Task Force Chair is Marilou McPhedran. Task Force Members are: Harvey Armstrong, Briar Long, Pat Marshall, Roz Roach. Task Force Coordinator: Karen Brown; Research Coordinator: Kathleen Gallivan.

Please mail submissions to:

Special Task Force, Suite 1800, 415 Yonge Street,
Toronto, Ontario M5B 2E7
Call our 24 hour toll-free line: 1-877-380-0490
Fax 1-416-595-7191
Email: sxabtf@web.net

MEDIA NOTICES REGARDING THE HEARINGS

The Globe and Mail, May 18, 2000



A6 • THURSDAY, MAY 18, 2000 NATIONAL NEWS THE GLOBE AND MAIL

WHAT DO YOU KNOW ABOUT SEXUAL ABUSE OF PATIENTS IN ONTARIO?

PUBLIC HEARING ON MAY 24, 2000

IN TORONTO - DELTA CHELSEA HOTEL

33 GERRARD ST. WEST from 10 a.m. until 8 p.m.

Presentations from patients, members of the public, and advocates groups to the Public Hearing on May 24th or at Private Hearings on May 31st are welcome. The Special Task Force on Sexual Abuse of Patients by Regulated Health Professionals has been appointed to conduct an independent inquiry into the experiences of patients and members of the public in order to provide Advice and Recommendations to the Health Professions Regulatory Advisory Council and the Minister of Health, as part of the five year review of *The Regulated Health Professions Act* in Ontario. ***Special Task Force:*** Marilou McPhedran (Chair). ***Task Force Members:*** Harvey Armstrong, Briar Long, Pat Marshall, Roz Roach.

For More Information, contact Karen at the

SPECIAL TASK FORCE

Suite 1800 · 415 Yonge St. · Toronto, ON · M5B 2E7

Toll Free Line: 1.877.380.0490

Email: sxabtf@web.net · www.yorku.ca / sex abuse

Appendix III

Questionaire

Questionaire sent to the Colleges in April 2000.

SPECIAL TASK FORCE ON THE SEXUAL ABUSE OF PATIENTS

QUESTIONNAIRE FOR ALL HEALTH REGULATORY COLLEGES

INTRODUCTION

Our time with you at the May 12th Roundtable is going to be quite limited, so we are asking for your cooperation in sharing information in advance on the experience of the regulated health professions in dealing with complaints of sexual misconduct and abuse. The following Questionnaire refers to policies, procedures, and practices regarding cases of alleged sexual abuse by health professionals. We are particularly interested in hearing about what you consider to be current problematic areas – for example, where you believe insufficient resources are a factor. We welcome your recommendations.

If you have written materials, including any guidelines used by your College, please include copies of them with your completed questionnaire. We appreciate that we may be asking you for information that you have already provided to HPRAC, but HPRAC has not made such material available to us at this time.

Please fill out the questionnaire to the best of your knowledge and return to the Task Force office by April 30, 2000.

PLEASE NOTE THAT THE
LOCATION OF THE ROUNDTABLE HAS
CHANGED TO THE

DELTA CHELSEA HOTEL
(ON GERRARD BETWEEN YONGE AND BAY)

11:30 A.M. THROUGH 3:30 P.M.

FRIDAY MAY 12, 2000.

SPECIAL TASK FORCE ON THE SEXUAL ABUSE OF PATIENTS

SECTION 1: HISTORY OF SEXUAL ABUSE COMPLAINTS AND OUTCOME

1. How many complaints about sexual abuse by your members have you received, by year, since 1994? [Please indicate numbers under the appropriate year]

1994	1995	1996	1997	1998	1999

2. Please identify the number of complaints and their disposition.

Year	Unfounded	Withdrawn	Proceeded to Discipline	Finding of Guilt	Mediation Used
1994					
1995					
1996					
1997					
1998					
1999					

3. In cases where there was a finding of guilt, how often were the following penalties used?

Year	Number of Cases	Revocation	Voluntary Resignation	Suspension	Condition	Other
1994						
1995						
1996						
1997						
1998						
1999						

4. Please rate your satisfaction with the following aspects of your complaints and discipline process using this 5-point scale:

Type of Process	5 Point Rating Scale				
	Very Dissatisfied		Satisfied		Extremely Satisfied
Intake Process	1	2	3	4	5
Investigations Process	1	2	3	4	5
Complaints Committee Process	1	2	3	4	5
Discipline Committee Process	1	2	3	4	5
Sensitivity and support for complaints	1	2	3	4	5
Use of Appeals Process	1	2	3	4	5
Mandatory Reporting	1	2	3	4	5
Appropriateness of penalties	1	2	3	4	5

5. Has your College had cases appealed to the Health Professions Board or a court?
☐ Yes ☐ No

If so, please describe and append decisions if available.

6. Please comment on problematic areas for your College or make Recommendations for Change.

SECTION 2: EDUCATION OF MEMBERS AND THE PUBLIC

1. Does your College provide education for your members around sexual abuse of patients?
☐ Yes ☐ No

If yes, please rate the quality of the education provided, using this 5-point scale [circle the appropriate #]:

Very poor quality		Satisfactory		Extremely good
1	2	3	4	5

2. Please describe how your College provides education to its members on sexual abuse by answering the following questions:

a. are any educational programs mandatory? 1 2 3 4 or more

b. have you issued any Guidelines for Respecting Boundaries? ☐ Yes ☐ No

c. how many of your members have participated in voluntary programs? ☐ under 100 ☐ over 100

3. Does your College provide information for the public around sexual abuse of patients, specifically:

a. availability of funding for therapy or counseling ?	☐ Yes	☐ No
b. steps and procedures in the complaints process ?	☐ Yes	☐ No
c. sexual abuse prevention plan ?	☐ Yes	☐ No

4. Please rate the quality of public education you provide, using this 5-point scale, for each of the areas listed below:

Very poor quality		Satisfactory		Extremely good
1	2	3	4	5

Availability of funding for therapy or counseling ___
Steps and procedures in the complaints process ___
Sexual abuse prevention plan ___

5. Please describe the methods used to provide education to the public:

6. How do you support equitable access to your complaints and discipline process (e.g. TDD lines, Braille, language interpretation, cultural sensitivities)? What are the criteria used to determine access to these services?

7. Comments/Problematic Areas/Recommendations for Change

SECTION 3: COMPLAINTS AND DISCIPLINE PROCESS

1. Do you have written criteria for deciding which cases will be referred to discipline?
☐ Yes ☐ No

If yes, please describe or append a copy:

2. To what extent is corroboration required for a case to be referred on to discipline?
[Please circle the most appropriate number from the scale listed below from 1 to 5]

Not Required		**Usually Required**		**Required**
1	**2**	**3**	**4**	**5**

Of the total number of sexual abuse cases that have been referred to a Discipline Committee since 1994, in how many have expert witnesses been used? _______________.

Does your Discipline Committee accept expert evidence based solely on a review of documents and files, with no personal interviews?
☐ Yes ☐ No

3. In how many cases involving sexual abuse has mediation been used since 1994? ____________

Please describe what limitations, if any, have been placed on the parties to speak publicly about the mediation process or results.

4. Do you have written criteria, policy, or practice established to determine which cases go on to mediation? Please describe:

5. What internal mechanisms are in place to monitor the quality of your complaints and discipline process?

6. Comments/Problematic Areas/Recommendations for Change

SECTION 4: SUPPORT FOR COMPLAINANTS

1. Do you have a designated support person in place to support complainants?
☐ Yes ☐ No
If yes, please describe in what circumstances and how they are used. If no, please describe current processes used by your college to support complainants:

2. What criteria do you use for providing funding from the counseling/therapy fund to patients?

3. How many complainants have applied for such funding since 1994? _____

4. How many complainants have received such funding since 1994? ______

5. In what range has the average award been?

   ☐ $0 - $500
   ☐ $501 - $1000
   ☐ $1001 - $1500
   ☐ $1500 - $3000
   ☐ over - $3000

6. Comments/Problematic Areas/Recommendations for Change

SECTION 5: EDUCATION FOR STAFF, COUNSEL, AND COUNCIL MEMBERS

1. To what extent are your Council Members educated on the RHPA provisions on sexual abuse?

Annually		Occasionally		Seldom
1	2	3	4	5

Please describe the training provided by your College to your Executive Committee and Council members on issues relating to sexual abuse of patients:

2. How is turnover specifically addressed in the training for your Executive Committee and Council members?

3. Please describe the training provided by your College to staff on issues related to sexual abuse of patients: [Please give examples for the following: Investigators, Intake Staff, Support Staff,]

4. Please describe the training provided by your College to legal counsel involved in prosecuting cases related to sexual abuse of patients:

5. Comments/Problematic Areas/Recommendations for Change

SECTION 6: RELATIONSHIPS WITH OTHER COLLEGES

1. Does your College have an ongoing relationship with other regulating colleges on issues related to sexual abuse of patients?

☐ Yes ☐ No

If yes, please describe the relationship:

2. In what ways could a larger College support a smaller College in the area of sexual abuse of patients?

3. Please describe some of the barriers that might prevent such a relationship:

4. Comments/Problematic Areas/Recommendations for Change

SPECIAL TASK FORCE ON THE SEXUAL ABUSE OF PATIENTS

Would your College be interested in participating in further meetings to develop Principles of Best Practices at some future date?

☐ Yes ☐ No

PLEASE FEEL FREE TO APPEND ADDITIONAL WRITTEN COMMENTS IF SUFFICIENT SPACE HAS NOT BEEN PROVIDED. THANK YOU VERY MUCH FOR YOUR HELP IN FILLING OUT THIS QUESTIONNAIRE. WE WILL SHARE THE RESULTS WITH YOU AT THE MAY 12TH ROUNDTABLE.

Sincerely,
Special Task Force on Sexual Abuse of Patients
Marilou McPhedran, Chair,
Members:
Dr. Harvey Armstrong,
Dr. Briar Long,
Ms. Pat Marshall
Dr. Roz Roach

ADDITIONAL WRITTEN COMMENTS:

Appendix IV

The Regulated Health Professions Act and its Procedural Code

EXCERPTS FROM:

THE *REGULATED HEALTH PROFESSIONS ACT**

Based on the electronic file from the Ontario Government website, Legislation Online, <www.gov.on.ca>This is not an official version.

*1991 Statutes of Ontario, 1991, Chapter 18

As amended by: 1993, C. 37; 1996, C. 1, Sched. G, S. 27; 1998, C. 18, Sched. G, SS. 1-23.

BACKGROUND

Following the release of the 1991 Final Report of the Independent Task Force on Sexual Abuse of Patients, the *Regulated Health Professions Act* ("the *RHPA")* was amended. The following amendments, which are related to sexual abuse, were introduced to the *RHPA* and the *Health Professions Procedural Code* (referred to in this report as *" the RHPA Code")*:

- **Sexual abuse of patients was made an act of professional misconduct and, for the first time, "sexual abuse of patients" was defined in legislation.**
- **Mandatory penalties were imposed for a finding of sexual abuse by a health professional. These included mandatory reprimands, and for certain specified types of sexual abuse, revocation of the health professional's certificate of registration. .**
- **The revocation period was set at five years, and reinstatements were made subject to prescribed conditions.**
- **Mandatory reporting by health professionals of other health professionals in relation to sexual abuse of patients, other prescribed acts of misconduct, incompetence and incapacity was introduced. Similar reporting requirements were imposed on persons operating facilities where health professionals practise.**
- **Protections against reprisals for persons who were required to comply with the new reporting requirements under the *Act* were added.**
- **Each College was required to establish a program to provide funding for treating sexually abused patients through therapy and counselling.**
- **Each College was required to establish a Patients Relations Committee responsible for outreach and education on sexual abuse.**

Regulated Health Professions Act

DUTY OF MINISTER

3. It is the duty of the Minister to ensure that the health professions are regulated and co-ordinated in the public interest, that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. 1991, c. 18, s. 3.

EXTENSION OF TIME LIMITS

26.(1) If the Board is satisfied that no person will be unduly prejudiced, it may, on reasonable grounds, extend any time limit with respect to,

- (a) the obligation, under subsection 28 (1) of the Code, of a panel of a Complaints Committee to dispose of a complaint against a member;
- (b) a Registrar's obligation to give to the Board, under subsection 32 (1) of the Code, a record of an investigation of a complaint against a member and the documents and things upon which a decision was made with respect to the complaint;
- (c) a requirement, under subsection 21 (1) of the Code, for a review or hearing by the Board; or
- (d) a request, under subsection 29 (2) of the Code, for a review by the Board.

LIMITATION

26.(2) The Board shall not extend the time limit set out in subsection 29 (3) of the Code for more than sixty days. 1991, c. 18, s. 26.

REGULATIONS

43.1 Subject to the approval of the Lieutenant Governor in Council, the Minister may make regulations governing funding under programs required under section 85.7 of the Code, including regulations,

- (a) prescribing the maximum amount or a means of establishing the maximum amount of funding that may be provided for a person in respect of a case of sexual abuse;
- (b) prescribing the period of time during which funding may be provided for a person in respect of a case of sexual abuse. 1993, c. 37, s. 3.

HEALTH PROFESSIONS PROCEDURAL CODE*

*** This Code is Schedule 2 of the *Regulated Health Professions Act*, 1991 ("the *RHPA"*) and is deemed by section 4 of the *RHPA* to be part of each health profession act. In this Task Force report, we refer to the Code as the "RHPA Code".**

SEXUAL ABUSE OF A PATIENT

1.(3) In this Code, "sexual abuse" of a patient by a member means,

- (a) sexual intercourse or other forms of physical sexual relations between the member and the patient,
- (b) touching, of a sexual nature, of the patient by the member, or
- (c) behaviour or remarks of a sexual nature by the member towards the patient.

EXCEPTION

1.(4) For the purposes of subsection (3), "sexual nature" does not include touching, behaviour or remarks of a clinical nature appropriate to the service provided. 1993, c. 37, s. 4.

STATEMENT OF PURPOSE, SEXUAL ABUSE PROVISIONS

The purpose of the provisions of this Code with respect to sexual abuse of patients by members is to encourage the reporting of such abuse, to provide funding for therapy and counselling for patients who have been sexually abused by members and, ultimately, to eradicate the sexual abuse of patients by members. 1993, c. 37, s. 5.

3.1 For every disciplinary proceeding, completed at any time before the time the register was prepared or last updated, in which a member was found to have committed sexual abuse, as defined in clause 1 (3) (a) or (b), the results of the proceeding.

COMPLAINT ABOUT SEXUAL ABUSE

4.(3) In exercising its powers under paragraph 4 of subsection (2), the panel may not refer the matter to the Quality Assurance Committee if the complaint is about sexual abuse as defined in clause 1 (3) (a) or (b).

REGISTER

23.(1) The Registrar shall maintain a register. 1991, c. 18, Sched. 2, s. 23 (1).

CONTENTS OF REGISTER

23. (2) The register shall contain,

- (a) each member's name, business address and business telephone number;
- (b) each member's class of registration and specialist status;
- (c) the terms, conditions and limitations imposed on each certificate of registration;
- (d) a notation of every revocation and suspension of a certificate of registration;
- (e) the result of every disciplinary and incapacity proceeding;
- (e.1) where findings of the Discipline Committee are appealed, a notation that they are under appeal;
- (f) information that a panel of the Registration, Discipline or Fitness to Practise Committee specifies shall be included; and
- (g) information that is required to be kept in the register in accordance with the by-laws. 1991, c. 18, Sched. 2, s. 23 (2); 1993, c. 37, s. 7 (1); 1998, c. 18, Sched. G, s. 13 (1).

SAME

23.(2.1) When an appeal of findings of the Discipline Committee is finally disposed of, the notation added to the register under clause (2) (e.1) shall be removed. 1993, c. 37, s. 7 (2).

ACCESS TO INFORMATION

23.(3) A person may obtain, during normal business hours, the following information contained in the register:

1. Information described in clauses (2) (a) to (c).

2. Information described in clause (2) (d) relating to a suspension that is in effect.

3. The results of every disciplinary and incapacity proceeding completed within six years before the time the register was prepared or last updated,
    i. in which a member's certificate of registration was revoked or suspended or had terms, conditions or limitations imposed on it, or
    ii. in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the register by a panel of the Discipline or Fitness to Practise Committee.

3.1 For every disciplinary proceeding, completed at any time before the time the register was prepared or last updated, in which a member was found to have committed sexual abuse, as defined in clause 1 (3) (a) or (b), the results of the proceeding.

3.2 Information described in clause (2) (e.1) related to appeals of findings of the Discipline Committee.

4. Information designated as public in the by-laws. 1991, c. 18, Sched. 2, s. 23 (3); 1993, c. 37, s. 7 (3, 4); 1998, c. 18, Sched. G, s. 13 (2).

WHEN INFORMATION CAN BE WITHHELD

23.3 (3.1) The Registrar may refuse to allow a person to obtain a member's business address and business telephone number if the Registrar has reasonable grounds to believe that disclosure of the information may jeopardize the member's safety. 1998, c. 18, Sched. G, s. 13 (3).

PANELS SPECIFYING INFORMATION IN REGISTER

23.3 (4) In disposing of a matter, a panel of the Registration, Discipline or Fitness to Practise Committee may, for the purposes of clause (2) (f), specify information to be included in the register.

PANELS DIRECTING RESULTS TO BE PUBLIC

23.3 (5) In disposing of a matter, a panel of the Discipline or Fitness to Practise Committee may, for the purposes of subparagraph ii of paragraph 3 of subsection (3), direct that the results of the proceeding be included in the register.

INFORMATION FROM REGISTER

23.3 (6) The Registrar shall provide to a person, upon the payment of a reasonable charge, a copy of any information in the register the person may obtain. 1991, c. 18, Sched. 2, s. 23 (4-6).

MEANING OF "RESULTS OF PROCEEDING"

23.3 (7) For the purpose of this section and section 56, "result", when used in reference to a disciplinary or incapacity proceeding, means the panel's finding, particulars of the grounds for the finding, and the penalty imposed, including any reprimand. 1993, c. 37, s. 7 (5).

TIMELY DISPOSAL

28. (1) A panel shall dispose of a complaint within 120 days after the filing of the complaint.

ALLEGATIONS OF SEXUAL ABUSE

36. (2) In deciding whether or not to refer an allegation of the sexual abuse of a patient to the Discipline Committee, the Executive Committee shall take into account any opinion, required under subsection 85.3 (5), as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future. 1993, c. 37, s. 9.

EVIDENCE IN CIVIL PROCEEDINGS

36. (3) No record of a proceeding under this Act, a health profession act or the Drug and Pharmacies

Regulation Act, no report, document or thing prepared for or statement given at such a proceeding and no order or decision made in such a proceeding is admissible in a civil proceeding other than a proceeding under this Act, a health profession act or the Drug and Pharmacies Regulation Act or a proceeding relating to an order under section 11.1 or 11.2 of the Ontario Drug Benefit Act. 1991, c. 18, s. 36 (3); 1996, c. 1, Sched. G, s. 27 (2).

36.5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the College for funding provided for that patient under the program required under section 85.7.

ADMISSIBILITY OF EVIDENCE

49. Despite the Statutory Powers Procedure Act, nothing is admissible at a hearing that would be inadmissible in a court in a civil action and the findings of a panel shall be based exclusively on evidence admitted before it. 1991, c. 18, Sched. 2, s. 49.

ORDERS RELATING TO SEXUAL ABUSE

51(2)5.2(5) If a panel finds a member has committed an act of professional misconduct by sexually abusing a patient, the panel shall do the following in addition to anything else the panel may do under subsection (2):

1. Reprimand the member.
2. Revoke the member's certificate of registration if the sexual abuse consisted of, or included, any of the following,
    - i. sexual intercourse,
    - ii. genital to genital, genital to anal, oral to genital, or oral to anal contact,
    - iii. masturbation of the member by, or in the presence of, the patient,
    - iv. masturbation of the patient by the member,
    - v. encouragement of the patient by the member to masturbate in the presence of the member.

STATEMENT RE IMPACT OF SEXUAL ABUSE

36. 5.2 (6) Before making an order under subsection (5), the panel shall consider any written statement that has been filed, and any oral statement that has been made to the panel, describing the impact of the sexual abuse on the patient.

REINSTATEMENT

APPLICATIONS FOR REINSTATEMENT

72.(1) A person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in
writing to the Registrar to have a new certificate issued or the suspension removed.

TIME OF APPLICATION

72.(2) An application under subsection (1) shall not be made earlier than,

(a) one year after the revocation or suspension; or

(b) six months after a previous application under subsection (1). 1991, c. 18, Sched. 2, s. 72.

TIME OF APPLICATION, SEXUAL ABUSE CASES

72.(3) An application under subsection (1), in relation to a revocation for sexual abuse of a patient, shall not be made earlier than,

(a) five years after the revocation; or

(b) six months after a previous application under subsection (1). 1993, c. 37, s. 18.

REFERRAL TO COMMITTEE

73. (1) The Registrar shall refer the application, if the revocation or suspension was on the grounds of,

(a) professional misconduct or incompetence, to the Discipline Committee; or

(b) incapacity, to the Fitness to Practise Committee.

HEARINGS

73. (2) The chair of a committee to which an application is referred shall select a panel from among the members of the committee to hold a hearing of the application.

PROCEDURAL PROVISIONS

73. (3) The following provisions apply with necessary modifications to a hearing of an application by a panel of the Discipline Committee:

1. Subsection 22 (4) (findings of fact).
2. Subsection 38 (2) (composition).
3. Subsection 38 (3) (composition).
4. Subsection 38 (5) (quorum).
5. Section 43 (no communication by panel members).
6. Section 44 (legal advice).
7. Section 45 (hearings open).
8. Section 47 (sexual misconduct witnesses).
9. Section 48 (transcript of hearings).
10. Section 50 (members of panel who participate).
11. Section 55 (release of evidence).

IDEM

73.(4) The following provisions apply with necessary modifications to a hearing of an application by a panel of the Fitness to Practise Committee:

1. Subsection 22 (4) (findings of fact).
2. Section 43 (no communication by panel members).
3. Section 44 (legal advice).
4. Section 47 (sexual misconduct witnesses).
5. Section 48 (transcript of hearings).
6. Section 50 (members of panel who participate).
7. Section 55 (release of evidence).
8. Subsection 64 (2) (composition).
9. Subsection 64 (3) (quorum).
10. Section 68 (hearings closed).

ORDER

73 (5) A panel may, after a hearing, make an order doing any one or more of the following:

1. Directing the Registrar to issue a certificate of registration to the applicant.
2. Directing the Registrar to remove the suspension of the applicant's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration. 1991, c. 18,
   Sched. 2, s. 73 (1-5).

LIMITATION FOR SEXUAL ABUSE CASES

73. (5.1) A panel may not make an order directing that the Registrar issue a new certificate of registration to an applicant whose certificate had been
revoked for sexual abuse of a patient unless the prescribed conditions are met. 1993, c. 37, s. 19.

DECISION

73.(6) A panel that held a hearing of an application shall give its decision and reasons in writing to the applicant and the Registrar. 1991, c. 18, Sched. 2, s. 73 (6).

ORDERS WITHOUT HEARING

74.(1) The Council or Executive Committee may, without a hearing, with respect to a person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings, make an order doing any one or more of the following:

1. Directing the Registrar to issue a new certificate of registration to the applicant.
2. Directing the Registrar to remove the suspension of the applicant's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration if an order is made under paragraph 1 or 2. 1991, c. 18, Sched. 2, s. 74.

LIMITATION

74.(2) This section does not apply with respect to a revocation for sexual abuse of a patient. 1993, c. 37, s. 20.

QUALITY ASSURANCE COMMITTEE

REFERENCE TO QUALITY ASSURANCE COMMITTEE

79.1 When the Executive Committee, Complaints Committee or Board receives a report under section 79 of the results of an investigation conducted into a possible act of sexual abuse as defined in clause 1 (3) (c), it may refer the matter to the Quality Assurance Committee. 1993, c. 37, s. 21.

PATIENT RELATIONS PROGRAM

84. (1) The College shall have a patient relations program. 1991, c. 18, Sched. 2, s. 84 (1).

MEASURES FOR SEXUAL ABUSE OF PATIENTS

84. (2) The patient relations program must include measures for preventing or dealing with sexual abuse of patients. 1993, c. 37, s. 22 (1).

SAME

84. (3) The measures for preventing or dealing with sexual abuse of patients must include,

(a) educational requirements for members;
(b) guidelines for the conduct of members with their patients;
(c) training for the College's staff; and
(d) the provision of information to the public. 1991, c. 18, Sched. 2, s. 84 (3); 1993, c. 37, s. 22 (2).

REPORT ON PROGRAM

84. (4) The Council shall give the Health Professions Regulatory Advisory Council a written report describing the patient relation program and, when changes are made to the program, a written report describing the changes. 1991, c. 18, Sched. 2, s. 84 (4).

TIMING OF REPORT, SEXUAL ABUSE

85.3 (2) The report must be filed within thirty days after the obligation to report arises unless the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients, in which case the report must be filed forthwith.

CONTENTS OF REPORT

85.3 (3) The report must contain,

(a) the name of the person filing the report;
(b) the name of the member who is the subject of the report;
(c) an explanation of the alleged sexual abuse; Reporting by employers, etc.

PATIENTS NOT NAMED WITHOUT CONSENT

85.3 (4) The name of a patient who may have been sexually abused must not be included in a report unless the patient, or if the patient is incapable, the patient's representative, consents in writing to the inclusion of the patient's name.

85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member or who dissolves a partnership or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons.

SAME

85.5 (2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Registrar within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act.

APPLICATION

85.5 (3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services. 1993, c. 37, s. 23.

FUNDING PROVIDED BY COLLEGE

85.7 (1) There shall be a program, established by the College, to provide funding for therapy and counselling for persons who, while patients, were sexually abused by members.

FUNDING GOVERNED BY REGULATIONS

85.7 (2) The funding shall be provided in accordance with the regulations made under the Regulated Health Professions Act, 1991.

ADMINISTRATION

85.7 (3) The Patient Relations Committee shall administer the program.

ELIGIBILITY

85.7 (4) A person is eligible for funding only if,

(a) there is a finding by a panel of the Discipline Committee that the person, while a patient, was sexually abused by a member; or

(b) the alternative requirements prescribed in the regulations made by the Council are satisfied.

EFFECT OF APPEAL

85.7 (5) A person's eligibility for funding under clause (4) (a) is not affected by an appeal from the panel's finding.

NO ASSESSMENT

85.7 (6) A person is not required to undergo a psychological or other assessment before receiving funding.

CHOICE OF THERAPIST OR COUNSELLOR

85.7 (7) A person who is eligible for funding is entitled to choose any therapist or counsellor, subject to the following restrictions:

1. The therapist or counsellor must not be a person to whom the eligible person has any family relationship.
2. The therapist or counsellor must not be a person who, to the College's knowledge, has at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature or been found civilly or criminally liable for an act of a similar nature.
3. If the therapist or counsellor is not a member of a regulated health profession, the College may require the person to sign a document indicating that he or she understands that the therapist or counsellor is not subject to professional discipline.

PAYMENT

85.7 (8) Funding shall be paid only to the therapist or counsellor chosen by the person.

USE OF FUNDING

85.7 (9) Funding shall be used only to pay for therapy or counselling and shall not be applied directly or indirectly for any other purpose.

SAME

85.7 (10) Funding may be used to pay for therapy or counselling that was provided before the person became eligible under subsection (4) but after the panel began its hearing into the matter.

OTHER COVERAGE

85.7 (11) The funding that is provided to a person shall be reduced by the amount that the Ontario Health Insurance Plan or a private insurer is required to pay for therapy or counselling for the person during the period of time during which funding may be provided for him or her under the program.

RIGHT OF RECOVERY

85.7 (12) The College is entitled to recover from the member, in a proceeding brought in a court of competent jurisdiction, money paid in accordance with this section for therapy or counselling for an eligible person referred to in clause (4) (a).

PERSON NOT REQUIRED TO TESTIFY

85.7 (13) The eligible person shall not be required to appear or testify in the proceeding. 1993, c. 37, s. 23.

OFFENCE

93. (1) Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than $10,000 for a first offence and not more than $20,000 for a subsequent offence.

IDEM

93. (2) Every person who contravenes subsection 76 (3) is guilty of an offence and on conviction is liable to a fine of not more than $10,000. 1991, c. 18, Sched. 2, s. 93 (1, 2).

IDEM

93. (3) Every person who contravenes subsection 82 (2) or (3) is guilty of an offence and on conviction is liable to a fine of not more than $5,000 for a first offence and not more than $10,000 for a subsequent offence. 1991, c. 18, Sched. 2, s. 93 (3); 1993, c. 37, s. 26 (1).

SAME

93. (4) Every person who contravenes subsection 85.1 (1), 85.2 (1), 85.4 (1) or 85.5 (1) or section 92.1 is guilty of an offence and on conviction is liable to a fine of not more than $25,000. 1993, c. 37, s. 26 (2).

Appendix V

REPRINT: 60 RECOMMENDATIONS, 1991

Sixty Recommendations made in the Final Report of the Independent Task Force on Sexual Abuse of Patients, commissioned by the College of physicians and Surgeons of Ontario, 1991.

LIST OF RECOMMENDATIONS

Recommendation 1

a) That the College immediately establish an **Implementation Committee** to implement all of the recommendations approved by the Council of the College. That the **Implementation Committee** consist of representatives drawn from College Council and staff at all levels, and, in recognition of their demonstrated expertise, at least three representatives of the Task Force and/or the Advisory Council who are not members of the College Council. We suggest that a senior member of the College be clearly charged with the responsibility of chairing the Implementation Committee and presenting a detailed annual progress report to the public, the Minister of Health, and the College Council at its Annual General Meeting in 1992, 1993, and 1994.

b) That the Minister of Health go beyond studying the issue of sexual abuse of patients and **reinstate** her proposal to add to the **Regulated Health Professions Code** a **Patient Relations Monitoring Board** or its equivalent to evaluate implementation by the College of Physicians and Surgeons of Ontario (and soon, other Colleges), so that the Government of Ontario continues to provide effective leadership to bring about solutions to the problem of sexual abuse of patients.

That the Minister of Health, should she decide to exclude the **Patient Relations Monitoring Board** from the **Regulated Health Professions Act**, nevertheless take immediate steps to appoint an **Evaluation Team** to monitor and report annually on the implementation of the recommendations of this Task Force, rather than wait until all the other Colleges in the **Regulated Health Professions Act** have "caught up" to the initiatives of the College of Physicians and Surgeons of Ontario.

c) That the **Evaluation Team** or its equivalent present an evaluation of the College's progress to the Minister of Health and to the Annual General Meeting of the College in 1994 that contains a recommendation as to the appropriateness of continued **self-regulation** in investigating members accused of sexual abuse of patients. That the evaluation be based, **at minimum**, on:

i) the use of well-publicized public hearings to gather information;
ii) a test of the system by professionals with expertise in sexual abuse, to check that complainants and physicians feel they are being heard, and that complainants and physicians are being treated appropriately;
iii) a review of any reinstatements granted to physicians whose licences have been revoked or suspended for sexual abuse;
iv) whether there has been an increase in the number of sexual abuse complaints received and processed by the College, and
v) the outcome of those complaints.

The Task Force believes that compliance with the philosophy of **Zero Tolerance** must be tested. One important test will be that there are no reinstatements of licences to physicians found guilty by the College of sexual abuse, unless all of the criteria for reinstatement specified in Recommendation 24 have been met.

That, should the recommendation in May 1994 be for continued self-regulation, that the Evaluation Team or its equivalent remain in place to continue to monitor and assess compliance, making an evaluation and public report to the Minister and the College every three years.

Recommendation 2

That the College initiate changes in medical training at all levels, including undergraduates, interns, residents, fellows, faculty, practising physicians, and foreign medical graduates to increase the time and content devoted to curriculum on sexual abuse, **and** that this training be included in examinations and accreditation throughout training and practice.

That the curriculum developed must reflect an understanding of the context in which sexual abuse and sexual abuse by physicians occurs, including: gender socialization, sex roles, women's equality issues, cultural variables, and the position of power the doctor brings to the doctor-patient relationship. It must also encourage development of healthy feelings, values, and self-awareness about sexuality. At minimum, the following subjects must be covered:

Improved Treatment for Sexual Abuse Survivors

- Knowledge of the magnitude of the problem of sexual abuse and sexual abuse by physicians, the consequences to victims, and issues of race, gender and class related to abuse.

- The range of problems with which victims of sexual abuse and sexual abuse by physicians present.

- Barriers to disclosure and how to facilitate disclosure.

- Management and treatment options including the need for specialized training to treat sexual abuse survivors effectively.

- The importance of checking for sexual abuse when history-taking, when this is appropriate, and how to do it appropriately.

- Strategies for recognizing, confronting, and treating abuse by colleagues and how to report knowledge or suspicion of abuse by colleagues.

- How to sensitively recognize and treat patients who, because of past sexual abuse or trauma, might perceive their physician's genuine concern as alarming and a threat to their integrity, and how to handle this appropriately.

- The recognition and appropriate care of victims of female circumcision.

Improved Understanding of Appropriate Interactions and Behaviours

- How to set and enforce appropriate treatment boundaries for oneself and the patient.
- How to discuss sexuality and sexual issues and how to perform examinations in an acceptable, non-abusive manner.
- How to give care and comfort, including touching, in an appropriate non-sexual manner.
- How to get help for oneself before abusing, including how to recognize signs in one's own behaviour that indicate that sexual abuse of a patient may occur.

Recommendation 3

That the College move swiftly to ensure that practising physicians also know:

- That, due to the power the physician brings to the physician-patient relationship, there is no such thing as gaining consent for sexual involvement with a patient.
- The warning signs of behaviour that indicate that sexual involvement with patients may occur, and what to do to prevent abusing.
- That a physician has a right to refuse to examine any area of the body of a patient or to terminate the relationship, if the physician feels that the patient is sexualizing the relationship, and how to do this appropriately.
- Where survivors of sexual abuse can find effective treatment.
- The physician's legal obligation to report sexual abuse by another physician (as proposed in Recommendations 15 and 16).
- The nature of the offences of sexual impropriety and sexual violation, as outlined in Recommendation 24.

Recommendation 4

That the College initiate the establishment of a **Joint Education Committee** on sexual abuse to develop and implement the necessary curriculum changes, methods of teaching, and accreditation/ examination processes. Membership on this **Joint Education Committee** must include senior representatives of the following groups and organizations:

a) government, including: the Ministry of Colleges and Universities and the Ministry of Health;

b) the medical community, including: the Ontario Medical Association (OMA), the Council of Faculties of Medicine, the Medical Council of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Psychiatric Association, the Ontario Psychiatric Association, the College of Family Physicians of Canada, the Ontario College of Family Physicians, the Association of Canadian Medical Colleges, the committee planning Education of Future Physicians of Ontario (EFPO), the General Practice Psychotherapy Network and the Ontario Hospital Association; and,

c) front-line advocacy organizations with relevant expertise, including: the Canadian Health Alliance to Stop Therapist Exploitation Now (CHASTEN), the Metro Action Committee on Violence Against Women and Children (METRAC), the Disabled Women's Network Canada (DAWN Canada), the Ontario Native Women's Association, and the Coalition of Visible Minority and Immigrant Women.

We suggest a sub-committee made up of the College, the Council of Faculties of Medicine, the OMA, the Ministry of Health, the Ontario Psychiatric Association and at least three advocacy groups be clearly charged with the responsibility of implementing the changes.

Progress reports from this Joint Education Committee must be presented to the annual general meeting of each of the membership organizations and to the **Minister of Health** each year for the next three years, beginning in 1992.

Recommendation 5

That the College establish a clear and ongoing liaison with the committee planning Education of Future Physicians of Ontario (EFPO) and the Council of Faculties of Medicine, to help facilitate the required changes in undergraduate medical education.

Recommendation 6

That the College, the Law Society of Upper Canada, and the Metro Action Committee on Violence against Women and Children (METRAC), together with representation from survivor advocacy groups and survivors, cooperate in developing a continuing education program geared to the effective investigation and prosecution of sexual abuse complaints against physicians and other health care providers, including training in appropriate treatment of child witnesses and vulnerable adult witnesses. Only lawyers who have completed this course should be eligible for selection as prosecutors of sexual abuse complaints at the College. (This recommendation is already in the planning stages by the College, the Law Society, and METRAC).

Recommendation 7

That the College, together with the Ontario Medical Association, the Ontario College of Family Physcians, the Ontario Psychiatric Association and survivor and patient advocacy groups such as the Disabled Women's Network Canada, the Patients' Rights Association, and the Metro Action Committee on Violence Against Women and Children (METRAC), and representatives from the Ministries of Health, Education, and Community and Social Services develop an information brochure for patients. That this brochure contain the **Physician's Commitment to Patients**, the indicators of appropriate physical examinations, the list of warning signs and examples of sexually abusive behaviours contained in this Report, the options available for reporting and for help, and how to access the College, including the address, telephone numbers, and who to contact. That this brochure be available in languages appropriate to consumers of health services in Ontario and in Braille and on tape. That the College require this brochure to be available in every location where physicians practise and require that it be provided by members to any patient who discloses sexual abuse by another doctor.

That the **Physician's Commitment to Patients** also be prepared in poster form, and include the right to appropriate medical examinations; the right to say "no;" the right to ask questions, the right to understand, to the best of the patient's ability, what is happening to his or her body during treatment; the right to report sexual abuse by a physician, and how to access the College.

That the College encourage and support in all ways possible the display of the **Physician's Commitment to Patients** poster in every location where physicians practise. That the College also encourage the display of the brochure and the poster at other health and treatment centres, schools, sexual assault care centres, health clubs, community centres, and public centres, and make them available to these centres.

Recommendation 8

That the College actively promote public awareness of its role, policies, and procedures, the **Zero Tolerance** standard, and the entire complaints and discipline process in as many ways as possible, beginning with production of a poster and a brochure. That these be available in languages appropriate to consumers of health services in Ontario and in Braille and on tape for those who are print handicapped. That the College, in cooperation with the **Ontario Hospital Association**, ensure the brochure is available in every location where physicians practise and encourage and reward the display of the poster there. That the College also encourage the display of the poster and brochure in the other locations in Recommendation 7 and make them available to these locations.

Recommendation 9

That the College initiate the establishment of a **Joint Committee on Medical-Psychotherapy** to review and recommend ways to ensure that physicians carrying out full-time or part-time psychotherapy have adequate training, particularly in the care of survivors of sexual abuse. Membership in this committee should include, at minimum, senior representatives of the College, the Ontario Psychiatric Association, the Medical-Psychotherapeutic Institute of Ontario, and the Ontario College of Family Physicians and the General Practice Psychotherapy Network. At minimum, the committee's recommendations need to address two issues:

1. How to ensure that physicians practising psychotherapy are adequately trained to treat sexual abuse survivors effectively, including training in appropriate boundary management.

2. How to prevent physicians who have lost their licences due to a finding of guilt related to sexual abuse from becoming unlicenced psychotherapists, with the potential to abuse patients again.

That the Committee issue preliminary recommendations and an implementation plan to the College and the Evaluation Team proposed in Recommendation 1 by June 1992.

Recommendation 10

That the College issue a guideline, effective immediately, that a physician should not have sexual contact with a former patient for a period of **two years** following the date of the last professional contact with the patient, even if the physician has formally terminated the professional relationship.

Recommendation 11

That the College issue a guideline, effective immediately, that, when the physician-patient relationship has been primarily for the purpose of **psychotherapy**, sexual contact with the patient is prohibited during the professional relationship and at **any time thereafter**, due to the lasting nature of transference and the power imbalance, and hence the potential for abuse created.

Recommendation 12

That in addition to immediately adopting and issuing the guidelines for doctors proposed by this Task Force, the College establish a **Guidelines Committee** to examine models from other jurisdictions and determine whether statutory changes would be more effective. That this committee include representation from the College and the Advisory Council to this Task Force, the Ontario Medical Association (including the Women's Issues Committee), the Ontario Psychiatric Association (including the Women's Issues Section), and at least two representatives of survivor advocacy organizations with demonstrated expertise in the area of physician-patient sexual abuse.

Recommendation 13

That if the information was obtained in the course of a physician-patient relationship where the patient is a physician, and the treating physician is satisfied that the patient has limited or withdrawn from practice to the extent required to eliminate risk of harm to other patients, the report to the College include a notation that the physician is in treatment and has agreed to limit practice appropriately and that the treating physician be required to notify the College when the physician-patient leaves treatment.

Recommendation 14

That the College re-issue its guideline that physicians should make a third party readily available to their patients at all times during internal examinations if the patient so wishes, that it be incumbent on the physician to inform the patient of the option to have a third party present, and that this precaution is essential regardless of physician/patient gender.

Recommendation 15

That the College issue a guideline immediately and that the **Regulated Health Professions Code** be amended so that it is **mandatory** that a member of the College notify the College in writing when he or she has reason to believe that another member of the College is or has been engaged in sexual impropriety or sexual violation, as defined in Recommendation 24, and that such information be recorded and retained by the College. A member who knows the name of the offender, even though the patient has not explicitly named the offender, is obligated to report the offender's name, but not the patient's name, unless the patient specifically so agrees in writing.

Recommendation 16

That the College make it a policy that any person who has knowledge of any sexual impropriety or sexual violation in a physician-patient relationship may report to the College, and the College must record and retain the information in relation to the physician, on a confidential basis, until the Registrar, in accordance with the statutory safeguards, including the approval of the Executive Committee of the College, proceeds with the investigation.

Recommendation 17

That reports by third-parties are to include the physician's name, but not the patient's name, unless the patient specifically so agrees in writing, and not the reporter's name, unless the reporter is a member of the College or unless the reporter agrees to identification.

Recommendation 18

That where there is more than one third-party complaint about a physician, the College's Director of Public Complaints and Investigations be required to bring the physician's file to the attention of the Registrar and the Executive Committee of the College, for a review of the evidence available and a decision on whether an investigation will be initiated.

Recommendation 19

That any person, health care facility, business, or organization be immune from civil liability for submitting a report of sexual impropriety or sexual violation to the College, when submitted in good faith and on reasonable grounds.

Recommendation 20

That the College immediately amend its licence application, guided by the precedent of the **Law Society of Upper Canada**, to include a non-exemptible requirement to answer questions to enable the Registrar and/or the Registration Committee to determine whether or not the applicant is of **good character** sufficient to be allowed to practise medicine in Ontario.

Recommendation 21

That physicians, as a condition of licensure or re-licensure, continue to be obliged to report on an ongoing basis to the College criminal charges against them and disciplinary action against them by other Colleges or professional bodies and be obliged to report civil suits initiated against them where the charges allege sexual abuse, and that the College check previous licensing bodies for such charges prior to granting a licence.

Recommendation 22

That the **Solicitor General of Ontario** be asked to initiate mandatory reporting to the Colleges listed in Schedule 1 of the **Regulated Health Professions Act** (RHPA) of any charge laid against an Ontario physician or other member of a Schedule 1 profession, as soon as the charge is laid.

Recommendation 23

That where the College has made a finding of guilt of sexual impropriety or sexual violation, it immediately inform other provincial Colleges of Physicians and other related bodies in Canada and the United States, specifically the **Board Action Data Bank** kept by the Federation of State Medical Licensing Boards in Fort Worth, Texas, and that a protocol for mutual reporting be developed by the College with the **Federation of Medical Licensing Authorities of Canada**.

Recommendation 24

That the **Regulated Health Professions Act** be amended to include **two levels** of the offence of sexual abuse of patients:

I Sexual Impropriety, and
II Sexual Violation

As defined in this Recommendation,

I. Sexual Impropriety will comprise any behaviour, gestures, or expressions that are seductive or sexually-demeaning to a patient; inappropriate procedures, including, but not limited to, inappropriate disrobing or draping practices that reflect a lack of respect for the patient's privacy or deliberately watching a patient dress or undress instead of providing privacy for disrobing; subjecting a patient to an examination in the presence of medical students or other parties without the explicit written consent of the patient or when consent has been withdrawn; examination or touching of genitals without gloves; inappropriate comments about or to the patient, including, but not limited to, making sexual comments about a patient's body or underclothing; making sexualized or sexually-demeaning comments to a patient; criticism of the patient's sexual orientation (homosexual or heterosexual or bisexual); making comments about potential sexual perfomance during an examination or consultation, except when the examination or consultation is pertinent to the issue of sexual function or dysfunction; requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation; making a request to date; initiation by the physician of conversation regarding the sexual problems, preferences, or fantasies of the physician; and kissing of a sexual nature.

The penalty range for Sexual Impropriety would include reprimand, apology, fine, temporary suspension of licence, with conditions, or any combination thereof.

II. Sexual Violation will include physician-patient sex, whether initiated by the patient or not, and engaging in any conduct with a patient that is sexual, or may be reasonably interpreted as sexual, including, but not limited to, sexual intercourse, genital to genital contact, oral to genital contact, oral to anal contact, oral to oral contact except Cardiopulmonary Resuscitation, touching breasts or genitals except for the purpose of appropriate physical examination or treatment or where the patient has refused or withdrawn consent, and encouraging the patient to masturbate in the presence of the physician or masturbation by the physician while the patient is present.

The penalty for Sexual Violation would be a mandatory revocation of licence for a minimum of five years and a fine up to $20,000.00.

That the **Regulated Health Professions Code** should be amended to include the fine and mandatory revocation of licence for five years for members found guilty of Sexual Violation. Once the mandatory five year revocation had been served, the physician would be entitled to apply to the Discipline Committee for reinstatement of his or her licence to practise medicine. The **Regulated Health Professions Code** should be amended so that upon application for reinstatement, the Discipline Committee, the Council or the Executive Committee must require the applicant to fulfill specific requirements including (see Appendix A for a detailed draft amendment):

- Having the College publish a notice of application which informs all physicians of the intention of the applicant to apply for readmission, and outlines how to contact the College with any relevant information prior to the applicant's readmission hearing.

- Providing a written brief demonstrating the ways in which readmission would be in the public interest.

- Making good all financial losses caused by his or her sexual abuse.

- Filing a statutory declaration setting out in full his or her business or employment activities during the period following revocation of his or her licence.

- Filing a certificate from his or her treating professional detailing the course of treatment entered into and stating the treating professional's opinion of the applicant's compliance with treatment goals and the success of treatment overall.

- Filing a certificate from an independent assessor who has evaluated the course of treatment and formed an opinion as to its success in ensuring that the applicant poses no danger to future patients.

- Filing a series of documents prepared by the treating professional and the assessor, including an assessment of how the abuse occurred, an outline of specific rehabilitation goals and whether or not they have been met and a list of specific changes in behaviour which have occurred through the rehabilitation process.

- Filing a re-entry plan developed by the independent assessor, which includes substantive safeguards to prevent further sexual impropriety or violation.

- Demonstrating a commitment to ongoing rehabilitation therapy, including submitting quarterly reports to the College on the status of his or her recovery.

In hearing an application for reinstatement, the Discipline Committee would be required to carefully consider each of the aforementioned documents, as well as:

Recommendation 24 (cont'd)

- Testimony from the applicant, the treating professional and the independent assessor as to the applicant's understanding of the harm done by his or her abuse and the effectiveness of rehabilitation in this case, the specific changes in behaviour which have taken place, the commitment to ongoing rehabilitation and specific rehabilitation goals, the proposed safeguards in place should the physician be reinstated, and any practice restrictions including monitoring which are recommended.

Having reviewed all evidence regarding the rehabilitation of the applicant, the Discipline Committee must be convinced that:

- The evidence presented, including expert evidence, satisfies to a substantial degree of medical and psychological certainty that the applicant will not abuse patients or other vulnerable persons in future.

- Readmission would be in the public interest (see Appendix B for draft amendment specifying reinstatement criteria).

Recommendation 25

That the privacy of patient/complainants be better protected by the College, given the exceptions to secrecy proposed in Section 31 of the **Regulated Health Professions Act**, by:

1) Immediately beginning to delete the name of patient/complainants from documents accessible to College staff or lawyers and their staff.

2) Omitting graphic intimate details which may identify the patient including personal information unrelated to the facts of the physician abuse in the Report of the Discipline Committee which is public and widely distributed.

Recommendation 26

That the College identify in Regulations to the Act examples of sexually abusive behaviours in the two-tiered offence and ensure that these behaviours are known and understood by the physicians of Ontario.

Behaviours considered Sexual Impropriety or Sexual Violation (see Recommendation 24) include, (the occurrence of, or attempt to, or inducement to) but are not limited to:

- Watching a patient dress or undress, instead of providing privacy for disrobing.
- Deliberately making sexual comments about a patient's body or underclothing.
- Making sexualized or sexually-demeaning comments to a patient.
- Criticism of the patient's sexual orientation.
- Making comments about potential sexual performance during a

examination or consultation, except clinical comments where the patient's purpose in seeking the consultation was to discuss sexual issues.

- Making a request to date.
- Subjecting a patient to an examination in the presence of medical students or other parties without the explicit consent of the patient.
- Requesting details of sexual history or sexual likes or dislikes when not clinically indicated for the type of consultation or presenting problem.
- Initiation by the physician of conversation regarding the sexual problems, preferences or fantasies of the physician.
- All contact with genitals without the use of gloves

Recommendation 27

a) That the College, together with the Metro Action Committee on Violence Against Women and Children (METRAC) develop hiring criteria and performance standards for staff who will be involved with individuals contacting the College about sexual abuse.

b) That immediate, substantive and ongoing training be provided to all College staff who may, in any way, have contact with an individual inquiring or complaining about sexual abuse, (including receptionist, secretary, investigator, inspector, patient representative, and manager) as well as every member of Council, especially those sitting on, or likely to sit on, the Complaints or Discipline Committee within the next two years. That this training must address the common tendency to blame the victim and must include at minimum:

- The nature of sexual abuse by physicians, the magnitude of the problem, the consequences to victims, and issues of race, gender, and class related to abuse.

- The range of ways a survivor may initiate disclosure or inquiry, and how to facilitate and handle disclosure, inquiries, complaints, and information dissemination in an appropriate, empathetic, and supportive manner.

- How to fully and appropriately explain the complaints and discipline process of the College to potential complainants.

- The options a complainant has to lodge a complaint of sexual abuse through the criminal and civil justice systems.

- How to address survivors and those making inquiries with sensitivity and respect (for example, not addressing or referring to an adult woman as "girl").

- The characteristics of Sexual Impropriety and Sexual Violation, as outlined in Recommendation 24.

Changes in the Investigation and Complaints Process

Recommendation 28

That the College make it a policy that the entire complaints and discipline procedure up to and including final decision and options to appeal, be explained in full to a complainant before he or she is asked to make a written complaint, including the steps in the process, the disposition of medical records, the options available, the requirements of the complainant, the possible outcomes, and the resources the College will make available to him or her.

Recommendation 29

That there be very **frequent, clearly-worded communications** on the progress of the investigation, complaint, and discipline process between the College and the complainant and between the College and the physician and that care be taken that any communication from the College to complainants and physicians or their representatives be respectful and not attempt to intimidate or obstruct access to justice. That the College check with the complainant or physician to ensure that such communication has been understood.

Recommendation 30

That the College make it a policy to offer to complainants assistance in writing a complaint, including the assistance of a sensitive, trained investigator or patient representative, as well as provide whatever assistance is necessary to those complainants with **special communications needs,** such as language interpretation, cultural interpretation, or sign language interpretation and the ability to make the complaint on tape, if needed. That these resources be made available at College expense.

Recommendation 31

That the **College** make it a policy to offer to complainants support and/or counselling from outside the College throughout the complaints and discipline process if he or she does not have any, and so wishes, including **support, counselling, advocacy**, and whatever assistance is necessary for complainants with special communications needs, and continue to cover the costs of transportation, accommodation, and child care expenses. That these resources be made available at College expense.

Recommendation 32

That the **College** retain expert advice to develop an action plan on how to effectively encourage **women doctors** to serve on the Council and that the College encourage the **Minister of Health** to facilitate further appointments of women, including **women who are members of racial minorities or who are disabled, as public members.**

- **That the College immediately increase the number of women and public members who sit on the Complaints and Discipline Committees; that the Complaints Committee and each panel of the Discipline Committee be composed of at least two women and the maximum possible number of public members; and that these panels be chaired by a member, not necessarily a doctor, with skill and training in adjudication of administrative tribunals.**

- All members of the Complaints and Discipline panels are to be selected for their **demonstrated understanding and expertise** in sexual abuse as one principal criterion, in addition to being open-minded and knowledgeable in other areas deemed by the College as relevant to its obligations in regulating the profession.

- Before sitting on any of these panels, all members must have completed the **training program** being jointly developed with the Law Society of Upper Canada and METRAC (Recommendation 6) as well as the College's own internal training program, once these programs are available.

Recommendation 33

That the College continue its policy that when the Complaints Committee is satisfied that there is enough evidence of sexual abuse "on the face of the file" (prima facie), the complaint should always be referred to the Discipline Committee.

Recommendation 34

That in sexual abuse complaints, the College begin immediately, as standard procedure, to exercise its existing **statutory authority to seize** the patient's medical records and any other relevant materials, with a search warrant if required, at the beginning of the investigation process, without prior notice to the physician.

Recommendation 35

That the College use the revised confidentiality sections of the **Regulated Health Professions Act** (Section 32(1)(b)) to commence a specific investigation when the Registrar determines whether other patients of the physician might be able to provide evidence related to the complaint by carefully reviewing the doctors' medical records for indications that other patients may be victims while ensuring that confidentiality of their medical records is protected. Each patient so contacted to receive a copy of the decision of the Complaints or Discipline Committee within six weeks of that decision.

Changes in the Discipline Process

Recommendation 36

That the College continue its policy that any decision not to refer a sexual abuse complaint to the Discipline Committee must be supported with a **full explanation in plain language** given to the complainant, and make it a policy that there be a genuine opportunity for the complainant to ask questions and receive answers about the decision. At the same time, the complainant must be fully informed of the appeal procedure to the Health Disciplines Board and that this process is separate from the College.

Recommendation 37

That, in order to help reduce the delay in hearing sexual abuse cases, the College actively recruit the public members needed to increase the number of Discipline panels to two, until such time as the **Regulated Health Professions Act** is amended to allow for more panels.

Recommendation 38

a) That the College make it a **policy** that the patient/complainant has **guaranteed Intervenor status** in the hearing and the option to have a support person as well as her legal representative present throughout the hearing. Should the patient's **competence as a witness** become an issue at the hearing, the patient should have the right to participate as a **party.**

b) That the **Regulated Health Professions Code** be expanded to give the Complaints and Discipline Committees the same discretion to specify parties as is currently held by the Fitness to Practise Committee.

c) That the **Regulated Health Professions Code** be amended to give explicit authority to the Discipline Committee to use its discretion in allowing **public interest intervenors,** who are not representing the individual or complainant but can bring important perspectives to the deliberations.

Recommendation 39

That the College make it a policy that, until the case is referred to the Discipline Committee, a complainant should be granted a reasonable **adjournment** - if she or he is feeling unable to continue.

Recommendation 40

That the College make it a policy that a prosecutor become involved in a case immediately upon a complaint being referred to Discipline, and that the complainant has a right to meet with the prosecutor, and participate in the **selection of this prosecutor** from a group of lawyers provided by the College.

Recommendation 41

That the College require that lawyers who prosecute sexual abuse cases for the College must have demonstrated expertise in the theory and practice of conducting a sexual abuse case and an appreciation of the impact on the complainant as well as on the physician. Once Recommendation 6 is implemented, that the College only allow lawyers who have completed the **program on sexual abuse** to act as prosecutors.

Recommendation 42

That the College make it a policy that the letter of complaint that goes to the doctor for response is not sent without the **complainant's explicit knowledge and consent.**

Recommendation 43

That the College immediately modify its current practice and require a pre-hearing procedure similar to that employed by the Ontario Pay Equity Tribunal and the Ontario Human Rights Commission, and to ensure the **fullest possible disclosure** of information from all parties prior to a hearing be required immediately.

Recommendation 44

That, when the defence puts forward good character evidence, the prosecution lead expert opinion that **evidence of good character** in professional and community life does not have any bearing on the **propensity** to sexually abuse.

Recommendation 45

That in all cases of sexual abuse, it should be argued by the College that the physician is incompetent due to his "disregard of the welfare of the patient of a nature or to an extent that demonstrates he is unfit to continue in practice" as in Section 50(1) of the **Regulated Health Professions Code.**

Recommendation 46

That, to the greatest extent possible, all prosecutions for sexual abuse must present as part of the case before the Discipline Committee evidence related to **actual harm** to the abused patient, **risk of harm** to other patients, the high probability of recidivism, and the current inability of rehabilitation programmes to determine prospectively that a particular abuser will not abuse again.

Recommendation 47

That the College hire an abuse survivor to assist the College in initiating the development of counselling resources for survivors of sexual abuse by physicians, including a **network of survivors** whom a potential complainant could consult with about the experience of pursuing a complaint before deciding to proceed.

Recommendation 48

That the College employ objective outside testing, on a regular basis, to ensure there is sufficient capacity to its **toll-free telephone line** to be accessible (i.e., not constantly busy) to a member of the public and that the College install a **TDD line** to meet the needs of hearing-impaired members of the public.

Recommendation 49

That there be statutory amendments to the **Regulated Health Professions Act** to override the **Statutory Powers Procedures Act** so that the current entitlement of the accused to reasonable information of any allegations should be matched with a requirement on the part of the defence to disclose evidence to be presented.

Recommendation 50

That the section of the proposed **Regulated Health Professions Act** which actually lengthens the time for investigating and presenting a complaint to the Complaints Committee from 60 days to 120 days, be amended to reduce the allowable delay.

Recommendation 51

That the Minister of Health and the Cabinet address the disadvantage created by two-tiered compensation of membership on College Councils under the **Regulated Health Professions Act** by immediately increasing the per diem of public members to the same amount received by College members, to be reviewed annually.

Recommendation 52

That the **Regulated Health Professions Act** be amended as follows:

a) To provide that the College can prosecute more than one sexual abuse case together and that Discipline panels may consider together the evidence from more than one complaint.

b) To authorize the Discipline panels to reach decisions without requiring corroboration in sexual abuse cases.

Recommendation 53

That the **Public Hospitals Act**, the **Mental Hospitals Act** and the **Private Hospitals Act** be amended to include a **positive obligation** on hospital administration to:

a) Include in the hospital's annual report (to be forwarded within one month of its release, to the Monitoring Board in Recommendation 1 or its equivalent to be established by the Minister of Health) specific

information on safeguards against sexual abuse of patients or staff including a thorough background check before hiring or giving admitting privileges, as well as practices, policies and procedures to prevent sexual abuse, and disposition of any complaints received including the disposition time of complaints about sexual abuse by hospital staff or patients.

b) Maintain the highest possible level of education for themselves and other hospital staff as to the actual damage done by sexual abuse including the likelihood that other patients and sometimes staff are placed at risk when an abuser is not reported and suspended;

c) Report to the College the names of all doctors against whom any complaint of sexual abuse has been brought by patients, members of the public, or staff.

That sanctions against inaction on the part of hospital administrators be developed, including that failure to comply with these obligations be subject to a fine of $5,000.00 to be paid to the Survivors Compensation Fund or its equivalent.

Recommendation 54

That the **Ontario Evidence Act** and the **Regulated Health Professions Act** be amended to create exceptions to the "hearsay rule" to allow statements of **children and vulnerable adults** into evidence, and to use expert witnesses to explain the impact of sexual abuse, utilise devices such as screens, 1-way mirrors and closed-circuit television, to protect those who testify; and the adoption of a code of ethics respecting examination and cross-examination of child and vulnerable adult witnesses.

Recommendation 55

That the **Regulated Health Professions Code** be amended to extend the **privacy protections** to include patient/complainants or witnesses in sexual abuse cases.

Recommendation 56

That the **Minister of Health** and the **Treasurer of Ontario** establish a **Survivors Compensation Fund** to receive all monies paid as fines for sexual impropriety or sexual violation. In addition, the doctor must pay into the new Fund the equivalent amount for fees paid by OHIP as "services" when, in fact, the doctor was sexually abusing the patient. As well, proceeds from a levy of 1% of the annual membership fee of the **Ontario Medical Association** (OMA) should be forwarded to the Fund as a clear demonstration by the medical profession of its collective responsibility to patients who have been harmed by a member of the profession. That the procedure for this remedy be established in consultation with the Women's Health Bureau of the Ministry of Health.

Recommendation 57

That the **Limitations Act** be amended immediately in keeping with the March 1991 Report of the Limitations Act Consultation Group so that there will be no limitation period whatsoever on sexual assaults occurring in or as a result of a relationship of authority, trust or dependency.

Recommendation 58

That the Professional Relations Branch of the Ministry of Health immediately provide to members of the **Health Professions Board** substantive training in understanding sexual abuse, similar to that described in Recommendation 27.

Recommendation 59

That the **Director, Public Appointments and Cabinet** immediately include demonstrated understanding of sexual abuse as an important criterion in the selection of people to sit on the Health Professions Board.

Recommendation 60

That the offence of "aggravated sexual assault" in the **Criminal Code** be amended to include "by a person in a position of trust or authority."